From X-Ray.

THE JOURNAL

OF THE

Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

THIRTY-FIVE hundred doctors in our society have entrusted to some 12 or 15 of their confreres the task of conducting the affairs of our organization.

Scientific, political, and civic problems continually confront them and often tax to the utmost the efforts of our representatives.

From an experience of more than twenty years I have found that the men to whom have been entrusted our affairs are invariably strong of character, honorable, outstanding in their communities and worthy of the responsibilities imposed upon them.

We bespeak for your official family a sincere endeavour to promote and abet to the fullest degree the interests of the Michigan State Medical Society, and through it those of the individual doctor.

DR. J. D. BROOK, *President,*
Michigan State Medical Society.

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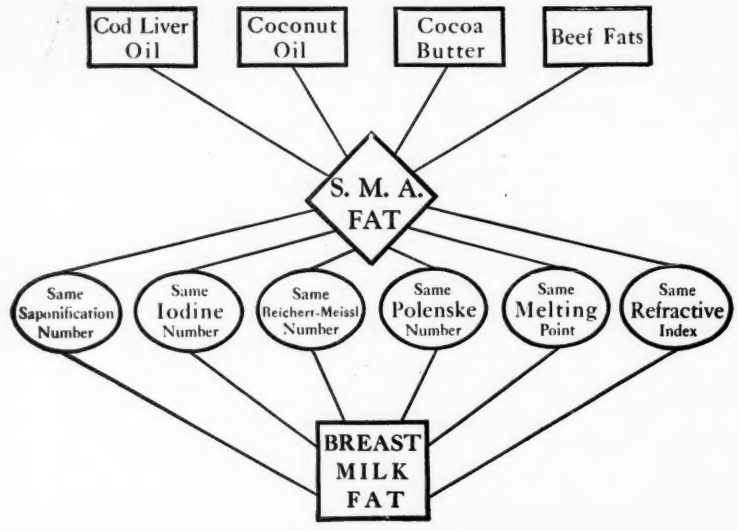

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CONTENTS

UNTOWARD RESULTS IN FRACTURES*

FREDERICK C. WARNSHUIS, M. D.

GRAND RAPIDS, MICHIGAN

In my practice, extending over twenty-seven years, the treatment of fractures and the securing of desirable end results has been a problem of intense personal concern. A recent review of the ever increasing volume of medical literature on the subject as well as repeated reviews of my own cases indicate that much remains to be attained before a satisfactory, uniform method of fracture treatment can be developed and generally adopted.

Untoward end results may be due to many underlying causative factors in which a large number of varied principles and errors of omission as well as of commission are concerned. Failures and untoward end results are mainly due to a lack of proper technic, the lack of necessary materials, improper preparation of patients and faulty after care. Theoretical knowledge is of little benefit in the absence of experience. Fundamental principles must govern. Careful examination and diagnosis, anatomic reduction, effective maintenance of reduction and early passive movement are fundamentals. Divergence from or neglect to apply these principles meticulously leads to untoward results. The results vary from zero to one hundred percent in efficiency and are largely influenced by the skill and judgment of the attending surgeon, the type of fracture and the patient.

Previous to the institution of the modern principles of aseptic surgery, treatment of fractures was limited to manipulative reduction and splinting. The operative or open treatment of fractures gained favor in 1894 when Sir Arbuthnot Lane began his pioneer work. As his results and teachings became widespread a furor of operative, open treatment of fractures ensued. Within a few years surgeons were deluged with a host of mechanical appliances and methods. The eager, aggressive surgeons plunged reck-

* Read before the Section on Surgery, Michigan State Medical Society Annual Meeting, Jackson, September 17, 18 and 19, 1929.

lessly into this new field of surgical reduction of fractures. On the slightest provocation the skill and ability formerly possessed to reduce and maintain in reduction by manipulation, traction and the proper splinting were cast aside. Then came the aftermath — infections, non-unions, osteomyelitis and a train of untoward end results. Before the war there was far too much operative treatment and calamities followed. With the advent of the war, the experiences recorded in army hospitals and a critical study of fracture treatment, the treatment of fractures has returned to a more conservative basis with careful observance of fundamental principles.

CAUSES OF UNTOWARD RESULTS

It will be impossible, at this time, to do more than enumerate the untoward factors. I present here a tabulation of untoward factors in the order of their importance as judged by my experience:

1. Faulty diagnosis or failure of diagnosis due to careless or superficial examination.
2. Incomplete reduction.
3. Failure to maintain reduction.
4. Too many readjustments.
5. Inadequate fixation.
6. Wide separation of fragments.
7. Interposition of muscles or loose bone.
8. Interference of circulation.
9. Focal infections and constitutional disease.
10. Injury to periosteum.
11. Ill advised open reduction.
12. Infection of open wound.
13. Osteitis.
14. Osteomyelitis.
15. Osteo-arthritis.
16. Pseudo-arthrosis.
17. Ankylosis of joint and nerve injury.
18. Failure to employ early passive massage and motion.

These factors cause non-union, vicious union, loss of bone, deformity and undue loss of function. They may and can be avoided by the skill, patience and care of the surgeon.

On what basis are these end results appraised? Ross[1] states that end results are based on time, anatomic position of fragments, condition of approximating joints, type of fracture and bones involved. Ross further observes that if the anatomic position is good relatively small loss of function occurs, if all other things are equal. He concludes that results are dependent upon firm union; that the long axis is continuous with the upper fragment; that the anterior surface of the lower fragment remains in the same plane as the upper fragment and that the length of the limbs are nearly equal.

Moorehead,[2] however, advances a more satisfactory basis of appraisal: First, Function, for it is the aim of surgical treatment to restore function as near normal as possible; Second, Union, state and condition of the union, and Third, Appearance—the contour and appearance of the injured limb.

PREVENTION OF UNTOWARD RESULTS

Preventive measures will materially reduce the incidence of untoward results. The degree with which we observe and apply guiding principles will in direct ratio minimize our failures and errors.

Diagnosis: Accurate, complete diagnosis is of first importance. This is impossible without careful and complete X-Ray examinations in all cases of suspected or possible fractures, regardless of the degree of the injury sustained. It is imperative to know accurately the nature and extent of the fracture and the extent of anatomic deformity before adequate treatment can be applied. This elementary advice is stressed because of almost weekly encounter with cases in which the attendant has been negligent in observing the first essential.

Reduction: If the nature and extent of a fracture are known the next procedure is its reduction. Here the judgment, skill and experience of the surgeon are of pronounced importance. Far too little time is spent in preparation for applying the most efficient reduction measures. Proper preparation of the patient, the table and the anesthetic, instruction of assistants and assuring the availability of splints, pads, cotton bandages and plaster will go far in preventing failures of reduction. The use of the fluoroscope is most helpful. In manipulations the soft parts must be respected. Brute force and disregard for muscle tension may early cause added injury that results later in untoward complications. Those who are not thoroughly familiar with the mechanics and the manipulative reduction principles of fractures will better delegate the manipulative reduction operation to experts in the treatment of fractures. Mention of the

1. A. S. Ross: "Journal of Medical Society of N. J., May, 1928."

2. J. J. Moorehead: "Journal of the A M A, Sept. 2, 1922."

necessity of complete anesthesia, whether by general, spinal or local methods might seem superfluous, but the failure to use an anesthetic is all too frequently the cause of non-reduction or faulty reduction. Again, a careful inquiry into the patient's constitutional condition must not be neglected for constitutional defects may alter methods of reduction. Much has been said regarding syphilis, but I have never encountered syphilis as a factor in non-union.

Preparation, full knowledge of the nature of the fracture and skilled manipulation will accomplish an anatomical re-alignment of the fragments in the preponderating majority of fractures. The results of Newel[1] who reports the necessity of only 64 operative reductions in a series of 2,000 fractures are characteristic of the possibilities of manipulative reduction and duplicate the results of many surgeons. The conversion of a simple fracture into a compound one is warranted only in exceptional cases.

Maintenance of Reduction: Satisfactory reduction, immediately confirmed by X-Ray, must be attended with positive maintenance of reduction by splints, plaster, traction and attentive after care. The results depend on the patience and skill of the surgeon and trained, carefully supervised hospital and nursing care.

Many indescribable types of splints and mechanical contraptions have been devised to maintain reduction of fractures. Some are useful while others are worthless. Each surgeon's experience determines their use in his practice. The best advice is for each surgeon to use such splints as he personally has found of value in enabling him to maintain reduction and institute early passive movement and massage. My own preference leans toward plaster paris in conjunction with suspension and traction frames in fractures of the leg, and the moulded plaster splints and airplane suspensions for fractures of the arm.

Appliances for the maintenance of reduction must accomplish four general purposes:

1. Hold the fragments in proper apposition.
2. Relieve muscle traction.
3. Permit passive movement of joints and massage of muscles.
4. Give comfort.

If these results are secured it matters not what is used, though the simpler the appliances the better.

1. Newel: "Sou. Med. Journal—August, 1927."

Passive Motion and Massage: The importance of passive motion and massage is well recognized though far too frequently neglected to the detriment of good results. The rigid immobilization of a limb and joints over a period of weeks and months is reminiscent of past decades and merits severe condemnation.

Open Operation. The assertion has been made that the large majority of fractures can be reduced and maintained by the so-called closed or non-operative method. Such an assertion can be easily defended. Certain fractures, however, present complications that prevent satisfactory reduction. In these, and only these, the open reduction is justified.

The complications requiring open reduction are: Interposition of soft parts or loose bone fragments, multiple disrelated comminuted fragments, inability to maintain reduction and apposition, certain compound fractures and concurrent injury to nerve trunks.

When other resources have failed and there are definite indications for open reduction surgical experience must dictate the surgical procedure.

In many instances exposure of the fragments, under most rigid aseptic technic, freeing of the fracture ends and placing them in apposition is all that is required in addition to the application of maintenance splints. The use of steel plates and screws may have been of value but their use is to be vigorously discouraged. Heavy silver wire is to be discarded in favor of thin phosphobronze wire of great tensile strength and even this may be caused to yield to some absorbable serviceable gut. Nails, ivory pegs, steel screws or plates may well be accorded a place in our museum, rather than in a fractured bone. Absorbable bone pegs, screws or plates are indicated at times. The intermedullary peg, loosely inserted, is of service in some fractures. The sliding bone graft evokes the least criticism and gives cause to the fewest complications. The Parnham metal band is potent for much mischief. End results will be more satisfactory in general when the least possible foreign unabsorbable material is inserted.

In operative interference a wholesome respect of the periosteum is imperative. Conserve it, replace it, guard against crushing it with clamps or forceps, never incise it circularly but always longitudinally, being ever mindful of its osteogenetic function and importance in osteogenesis. Let there be a minimum of trauma of soft

parts. Divide muscles in their planes and not through their bodies. Conserve nutrient vessels. Use a minimum of suture material to close and use a rat-tail drain for a few days. Desist attempting wound sterilization before closure by pouring in iodine, ether, alcohol or other solutions. If the technic has remained unbroken these antiseptics are superfluous and even if an error of technic has occurred these solutions are potent for greater mischief.

Skilled operative reduction is attended with good results while injudicious operative interference is frequently resultant in more serious complication and untoward results than those that would have been recorded were open surgery not employed.

NON-UNION—FAULTY-UNION

Just when to assert that non-union exists is difficult. Do not become too ready to assert that non-union is present. Time is most important and its length depends on the patient, the type of fracture, the complications and the treatment that is or was employed. When non-union is definitely established and in cases of vicious union there is but one treatment—the open operation on the fracture, undoing previous treatment errors, refreshing fracture ends,. the use of massive sliding grafts, followed by the application of maintenance splints and consistent, persistent after care.

Fractures demand and require the exhibition and application of the highest degree of surgical judgment, surgical skill and unceasing, ever hovering and alert after care to minimize our untoward end results.

CONCLUSIONS

Such complications as Ischemic muscle atrophy and contractures, pressure ulcerations, constitutional complications of pulmonary, renal and cardiac involvement, emboli, and the time of immobilization, have a bearing upon end results and demand of the surgeon most skilled attention. Conclusions:

1. Accurate, careful diagnosis must be made before the proper treatment can be instituted.

2. Reduction can be accomplished by manipulation, under anesthesia in the large majority of fractures, thereby obviating the open operation.

3. The immobilization appliances should be simple but must maintain accurate apposition of the fragments.

4. Early passive motion and massage are imperative.

5. Frequent X-Ray examinations and persistent after care must characterize after treatment.

6. Open operation should be resorted to only in reduction failure, when soft parts or bone fragments interpose, in extensive comminutions and when reduction cannot be maintained by adequate splints and traction. In operative interference the use of unabsorbable material should be avoided.

7. When non-union or faulty union occurs the open operation with the use of large, sliding autogenous bone grafts, affords the best end results.

8. Treatment of fractures that is characterized by a minimum of untoward end results demands the highest type of surgical skill combined with a wide experience in the treatment of fractures.

DISCUSSION

DR. JOHN T. HODGEN (Grand Rapids): Dr. Warnshuis is desirous of a uniform method of reduction and the after-care of fractures. In my opinion there is no uniform reduction of fractures and there is no uniform after-care for most individuals because we all have a biological susceptibility to a mechanical turn of mind, either to a greater or lesser extent, so I think at the present time we have no uniform method.

One thing I should like to bring out as regards the treatment of Colles' fracture, is muscle fixation. By muscle fixation I mean after our Colles' fracture has been reduced and put up in a plaster, the individual should be taught how to fix his muscle in the splint. The preferable method to your plaster appliance is a posterior splint and an anterior splint, or a splint on your extensor surface and a splint on your flexor surface, after you have reduced the fracture by the muscle fixation method of exercise. Under those circumstances you will not get so much fixation of the flexor tendons as you will if you allow that patient to go along for a week, which is the usual length of time that we put these Colles' fractures up, and another point I wish to bring out is that an anterior splint and a posterior splint are much more comfortable for the patient than either a posterior or anterior splint.

I think it should be ruled in every hospital that an X-ray picture should be required before operation for the surgeon to make up his mind how to treat that fracture, because every fracture is a law unto itself. It should also be a law in every hospital that an X-ray is required before the patient leaves the hospital. That should be a law in every hospital in this state. I think it behooves the individuals who are on these staffs of various hospitals, and I think it is their duty, to teach the internes the principles and the primary factors of fracture work, and by that I mean not only the reduction and the after-care and the care of the patient, but plaster work. I believe that there is nothing so mechanically difficult as excellent plaster work, and the idea of the average interne (I know I had it and I think it is the average idea of the interne) is that plaster work is extremely simple,

but it is not. It takes years of practice in order to be an expert in the application of plaster.

I believe at the present time that there are very few fractures which cannot be put up with plaster except in a very few cases, for instance leg fractures or certain types of arm fractures, but I believe the ordinary splints which are put out by the instrument houses at the present time are not adequate, and I do believe that we will get better results in our fracture work if we use more plaster.

The Mayo Clinic at the present time is doing much more open operative work on fractures than heretofore. There are certain types of cases in which they always use the open method, as I understand. One of those, fractures of the femur and fractures of both bones of the forearm, as you know, is a very difficult case to reduce. So I think as time goes on there will be a tendency more and more to use open work in our fractures.

DR. FRED C. KIDNER (Detroit): Dr. Warnshuis has said so large a mouthful that there is really very little to add to what he said, but there are certain points we can accent. In my work as an orthopedic surgeon I see an enormous amount of bad results from fractures, and there are certain points which stand out in causes of these bad results. Dr. Warnshuis has mentioned most of them. First, in my mind, however, is the delay in the reduction of the fracture. The ordinary fracture can be reduced easily without much physical effort, often without pain to the patient if it is done within a half hour. It can be easily done sometimes without an anesthetic, but usually not, up to four or five hours after the accident. After that time all fractures become difficult. I want, therefore, to bring very strongly before you the necessity of immediate reduction.

During the war, fractures of femurs in the French and the English armies during the first two years caused ninety-five per cent death. During the last two years through the introduction to the stretcher-bearers of the Thomas splint, that mortality was reduced to twenty-seven per cent. In other words, the stretcher on the field, when they found a man with a fractured femur, could reduce that fracture by putting on a Thomas splint with a nail through the sole of his shoe and tying that nail to the bottom of the splint just as tight as they could.

Fractures which are reduced very early do not ordinarily swell. If a fracture of both bones in the lower leg is seen within an hour or two and reduced with very little force used by the surgeon, with the aid of the fluoroscope, an accurate apposition of the ends can usually be obtained and the fracture can be put up in plaster of Paris then and there, circular plaster of Paris, properly applied, and there will not be sufficient swelling to do any harm. That is not safe to do unless you can watch your patient. If swelling does occur it is easy to split the plaster. That is the first thing. My plea is for early reduction.

The second thing is the matter of operation. Certain fractures do have to be operated on, notably such fractures as the "T" fractures around the elbow, comminuted fractures where alignment cannot be obtained by manipulative results. Those should not be operated upon unless one has had a large experience in the technic of bone surgery. They should be referred to somebody who has had that experience, because the dangers are tremendous. Those open operations should never be done until the period of swelling has practically subsided. Operation done through the hemorrhage and through the great edema which follows a fracture is inviting infection.

Causes of non-union, if such a thing exists, are, as has been said, inaccurate reduction and inefficient methods of fixation in good alignment.

Function is the most important thing that we have to look for in the results of fractures. Alignment is necessary, deformity is not pretty, but a moderately deformed fracture with useful joints is far better than a perfect one with stiff joints.

I have never seen syphilis have any influence on the healing of fractures. I fully agree that metal of any sort placed in contact with fractured bones is a mistake unless it is absolutely necessary. There are occasional fractures which cannot be held (at least the skill of the individual is not able to hold them) without some form of metal apparatus. If it is put on it should be taken off at the earliest possible moment in all cases.

Traction will reduce a vast majority of difficult fractures. The oblique fracture of the femur, which we see in the early stages and which we attempt to reduce on the fluoroscope table and then put up in some retentive apparatus, is very apt to slip by, and incidentally a plaster of Paris spica on such a fracture is a delusion and a snare. I have been putting on plasters for thirty years and I cannot hold an oblique fracture by that means. The traction of the muscles is so great that the plaster will be pulled up and out into the groin and then will have to be cut away at the groin until finally it becomes only a fixation apparatus without the extension element at all.

The time of operation should always be after the swelling has gone down. The time of closed reduction should always be, if possible, before the swelling has occurred, and that leads to one more point which I want to make before I sit down: The fact that a fracture is compounded, the fact that there is loss of tissue, the fact that there is great swelling when we first see our fracture, should in no way deter us from reducing that fracture. The reduction of a fracture, even under those bad circumstances, puts the tissues at rest and will very frequently lead to a prompt subsidence of the swelling and will very frequently help us to avoid infection.

DR. W. J. CASSIDY (Detroit): I have put in a good many hundreds of bone plates. I have put in bone grafts. I have opened them in the country on the kitchen table, and my septic wound infection has been less than one per cent. I have not seen these terrible results that it is claimed these metal appliances produce. My genial friend, Sherman, of the United States Steel, I think has put many, many hundreds in, and he has not had this terrible mortality and infection these men are telling us about. It isn't the little steel plates that are put in that make the infection; it is the fellow who puts them in. If you are a good laparotomist, you may be a poor bone surgeon, because you have to learn one thing in bone surgery, that is a minimum gentle handling of tissues using a simple line of force, using your knees or your long bones, and reducing with a minimum amount of effort the ends of the bones and then a little gentle clamp with a minimum amount of screws. Some put on a nice bone plate with thirty or forty pounds extension on a Holly table, leave it and screw the plates down. The fractured bones are pulled

apart and the plate won't let them go back together.

It has not been my experience to see these non-unions as the result of plate implantations. I will show you as many persons who have had no plate insertions. I will show you as many in individuals who have never had an open operation on their long bones. That is an individual problem. Bone grafts do not always cause non-unions to heal. I will show you patients with five to six bone grafts done by various men in the country.

A massive bone graft is advocated by our friend in Rochester clinic and it comes back with a non-union as bad as the other fellow has. In some of these cases you can't get union. Why, it is sometimes impossible to explain. You see some cases where there has been practically no displacement in which there has been a very, very minimum amount of trauma applied to the external part of the leg and also a minimum amount of handling. It is not due to that, nor is it due to too much manipulation. You see it sometimes in a simple fracture without fragmentation. It is always due, as a rule, to an inherent condition in that individual himself.

In applying principles you can't apply the same principles to a fracture of the long bone that you do to a fracture of the flat bone. You can't apply the same principles to a fracture of the leg as you do to a fracture of a bone of the head. Your skull fractures have for their basic fundamentals relief of intercranial pressure and intercranial hemorrhage, whereas your long bones have to deal principally with the deformity and as accurate reduction as you can possibly do consistent with a good workable leg. A great deal has been blamed upon the doctor, a great deal should be blamed upon the X-ray, for the reason that since the advent of the X-ray, surgeons and the laity at large being shown the plates demand greater apposition of fragments than they did before. Many, many of these fragments which are rayed long periods after they were set in the early days, with the X-ray show marked deviation from the general alignment, but being in the fleshy parts of the leg they didn't show any external deformity, the patients had very little shortening and practically no joint limitation. Since the laity see the X-ray plates, they demand closer reduction, and that often gets you into trouble, because while apparently at the time you saw it or at the time of your first application or immobilization you had a fair reduction, then somebody comes along and says, "My, what a terrible looking fracture you have; it is a half inch out of place. You are going to have a short leg, a crippled leg." Then the fun starts, and somebody starts manipulating, and as a general rule multiple manipulations often end up in closed reduction in order to proximate the fracture.

DR. JAMES MATTHEWS (Detroit): There are a lot of things that come up in one's experience in fractures, and the treatment of those conditions is only alluded to. I was amused a moment ago when someone spoke about the fractured femurs with enormous swelling, and I was wondering if he had a remedy for that. It is a very formidable thing to go up against a femur with a large displacement, a lot of swelling, having stood for several days before treatment is begun, and the question arises in your mind: What would be done for a condition like this? I suppose many men would think the same as I was thinking. Probably you have seen them. I have seen them. In a case like that, in my own experience, I think an anesthetic is indicated, or some form of anodyne, and vigorous massage resorted to, sufficient to cause fatigue of those swollen muscles, the limb being put up, of course, in extension and suspension and counter-extension, naturally, and from that time on, in a Thomas splint, with daily massage. If those fractures do not come together on this first manipulation, it has been my practice to put a heavy weight on, thirty or forty pounds, for an hour, and then reduce it to twenty for two or three hours, and return to the thirty-five pound weight again, or thirty-eight pounds, as the case demands. It is surprising how those bone fragments will come together. That is one point, and I think possibly you will get something from it.

The next thing I want to call attention to is these plaster casts that have been referred to. I am a firm believer in plaster casts. I think there is no treatment so wonderfully effectual in fracture of necks of the femurs than the plaster cast if you have sufficient abduction. That is the big thing. You will get a wonderful recovery, there will be no shortening, and I emphasize the abduction feature.

The next thing with a plaster cast is that it should not be left on there for six weeks or two months or three months, as the case may be. That cast should be opened on the third or fourth day and daily massage begun. Gentlemen, I can't tell you in words the importance of this daily message in fractures. I don't care where the fracture is. There is as much to contend with in the broken bones and traumatized periosteum, there is as much to be looked after in those soft tissues as in the bony structure. One is just as important as the other, because it is the soft tissues that give you most of your trouble. I think you will all agree with me on that, and the massage is a wonderful remedy for those soft tissues if you use your judgment as to the amount.

There is another point I want to bring out. Many of you have seen these fractured femurs with non-union, I mean the neck of the femur, in people past the age of seventy. I have seen quite a number of those. I have followed other men on them. Only recently I saved a damage suit on one of those. There is only one thing to do with them. You can't operate an individual past seventy with a non-union fractured neck of the femur. It is a hazard, and a big one. Those cases do very nicely by applying a caliper, and you will get a fibrous union. It will enable that man or woman, as the case may be, to get around, to attend to his daily duties, to go out in his garden, with the assistance of a cane; he can visit his friends, he can go out in his motor car, and so on. Otherwise he would be lying in bed or in a wheel chair. You can do nothing more for them than get a fibrous union, and this caliper measure can do that if it is adjusted to the case.

Most of these fractures I see with somebody else occasionally, I notice a stiff knee. That is something that a plaster cast will do. If you put a cast on a man's fractured femur for six weeks or longer, two months they usually leave it on, you are going to have a stiff knee. That is a hard thing to handle; that is a hard thing to correct afterward. Many times there is a damage case or it comes before the compensation board. That can be obviated by this cast or this Thomas splint cast being opened, or if you use a Thomas splint you have it exposed so you

can do massaging, and at the same time give a little passive motion on the knee daily, and that would obviate a stiff knee. I can't emphasize too strongly because I have seen some of those, and there are cases that are not desirable cases to meet on the street, these fellows that have stiff, painful knees after your treatment. You will hear a lot of criticism, and it is very unpleasant, particularly in a small town where you have prestige and you have two or three fractures that don't turn out well. You might as well move out of town. In the city, of course, it is different. You don't come in contact with them and you get by.

It is a big subject in surgery. I don't think there is any department of surgery to be compared with the surgery of bones or the handling of fractures. More depends on it. That man wants to return to his former vocation in industry and if he has a disability it is impossible to have the same earning capacity.

DR. F. C. WARNSHUIS (Closing Discussion): I appreciate the discussion. The only thing that inspired this paper was the experiences that we come across. Your State Society has a medico-legal defense committee which defends men against suits of civil malpractice. In an experience of twenty years we have found that the two chief claims that are made against doctors are for malpractice in throat operations and malpractice in the treatment of fractures.

It may not be your individual experience in your community to encounter these situations. When we have come into the office the call for assistance once or twice a week from members of our Society for defense in malpractice, then it becomes a subject that we as a state profession should take some definite action upon, and in our professional work be a little more particular and guarded in the method by which we treat these fractures.

Just last month three claims for defense came into the office, one for a Colles' fracture where the attending doctor without an anesthetic, without an X-ray, merely put on a plaster splint, left it on for pretty nearly nine weeks, and you can imagine what the result was. The next one was a comminuted fracture of the tiba and fibula in which there was no X-ray, there was no consultant, no effort apparently was made at a reduction, but a plaster cast was applied and left on for fourteen weeks. You can imagine what the result was. Another case was a fracture in one of the elderly people referred to, in which the doctor made no attempt at a diagnosis, except having the woman in bed nearly two months, and then an osteopath transported her to his private office (the doctor said she could not be transported) where he had a few beds, as we find in some of the smaller towns, took an X-ray and revealed to the people the existence of a fracture, another claim for suit. That is the reason I have tried to summarize the problem of fracture treatment and indicate an outline of what our untoward results are and why they are, in order that then we might be a little more careful and observe the principles that have been so well enunciated by both Dr. Hodgen and Dr. Kidner.

RADIUM EFFECTS DUE TO CAUSE OTHER THAN COSMIC RAYS

Whatever it is that makes radium, and related elements, disintegrate and give off the rays that are so helpful both to the physicist and the physician, the cosmic rays are not responsible. This has been found by Dr. Louis R. Maxwell, National Research fellow working at the Bartol Research Laboratory of the Franklin Institute. He will report his latest researches in the forthcoming issue of the institute's journal.

Shortly after the discovery of radium and its effects, over 30 years ago, the suggestion was made that some highly penetrating rays bombarded the earth from space, and were absorbed by certain elements. This energy, it was thought, might break up the radium atoms, and be given off again as rays of longer wave length.

The eventual discovery of such highly penetrating rays, which have been particularly studied by Dr. R. A. Millikan, of the California Institute of Technology, brought a renewal of interest in this theory. Though these rays from space are highly penetrating, they are completely stopped by a thickness of 225 feet of water, or equivalent amounts of other materials.

Dr. Maxwell took some polonium, another element in the radium series, and measured the rate at which it disintegrated on the surface of the ground, and in a mine 1,150 feet below the surface. The mine contained a large quantity of a zinc ore, willemite, which is more absorbent of the rays than water. At the depth at which the experiment was performed, the material above absorbed as much as 400 feet of lead, or more than half a mile of water, so that it was certain that no cosmic rays could reach the instruments.

Despite this, the rate of decay of the polonium was almost exactly the same whether the experiment was done on the ground or in the mine, and thus Dr. Maxwell concludes that there is no appreciable effect of cosmic rays on radioactivity.

As a matter of fact, his calculations show that it is unreasonable to expect any such effect. Only once in some 20,000,000 years would a cosmic ray be absorbed by a polonium atom, in the apparatus, so feeble are the rays. This would make it entirely impossible to measure the effect of the absorption of a ray by an atom, and also shows that the vastly more frequent breakup of the polonium atoms cannot be due to such an absorption.

Aven if the cosmic ray is something like a bullet, and merely has to pass near a polonium atom to break it, they cannot be held responsible, Dr. Maxwell points out. With the size of the polonium plate used, only two cosmic rays would reach it every second, while 3,000 atoms of polonium in it disintegrate every second. Thus less than a tenth of one per cent of distintegration could be blamed on the cosmic rays.—Science Service.

UNDULANT FEVER

In 125 cases of undulant fever that occurred in Iowa, a clinical investigation made by A. V. Hardy, Iowa City, revealed that most of the patients lived on farms or in country towns. The occupational groups chiefly involved were farmers and packing house workers. There was a striking variability in the symtomatology and course. The relative frequency and severity of the common symptoms is shown. Positive physical observations were few, the most frequent being an enlarged spleen. The temperature was generally intermittent or remittent, and undulations were not often apparent. The diagnoses were confirmed by agglutination tests, almost always repeated, and, when possible, by blood cultures.—Journal, A. M. A.

EFFECT OF VAGAL PRESSURE ON CARDIAC RATE AND RHYTHM

W. J. WILSON, M. D.*
DETROIT

Personal interest in the subject of vagal stimulation was aroused through its effect on a patient suffering from paroxysmal tachycardia in April 1921. At the time of the first examination, the pulse-rate was 160, systolic blood-pressure 95, diastolic 75. On pressure simultaneously of both vagi, he became unconscious. There were clonic contractions of the muscles of the arms, of the upper portions of the body and of the head. It was noted at this time that cardiac standstill had been produced. On releasing pressure, which was done almost immediately, a premature systole was noted, after which the cardiac rate, determined by auscultation, was 86. Electrocardiograms taken later that day in the office, showed normal rhythm.

Since that time, we have used vagal pressure in a great number of cases but never have pressed on both vagi simultaneously. Although much has been written in the literature on this topic, no electrocardiographic studies have been published. We therefore proceeded to take, in a routine manner, 160 cases, first using the effect of right vagal pressure only, which was done in 72 cases; later with pressure, first on the right and shortly afterward on the left vagus, in 88 cases. Of the 160 cases in which pressure was used on the right vagus, the rate was slowed in 57, or 35%. In 19, the rate was increased, while in 84 there was no change. With pressure on the left vagus, the rate was slowed in 36 cases or 40%, increased in 6 and there was no change in 46 cases. No change was apparent in either side in 16 of these cases. On considering the effect of vagal pressure on both sides in the same patient, the rate was slowed by right vagal pressure in 21; by pressure on the left vagus in 35. With pressure on either, the ventricular rate was slowed in 14 cases. Cardiac standstill was produced in 5 cases; in two of these cases, right vagal pressure only was tried. Left vagal pressure was effective in 2 cases, right in 3 cases, pressure being tried in 3 cases on both sides. Summary:

EFFECT OF VAGAL PRESSURE

Pressure on both right and left vagus	Cases 88
Pressure on right vagus only	Cases 72
Total	160

Pressure on right vagus:		Pressure on left vagus:	
Rate slowed	57 or 35%	Rate slowed	36 or 40%
Rate increased	19	Rate increased	6
No change	84	No change	46
Total	160	Total	88

No change on either side	46
Both sides in same patient	88
Rate slowed on right side	21
Rate slowed on left side	25
Total	56
Rate slowed on both sides	14
Number affected	42
Number not affected	46
Cardiac standstill — Number of cases	5 or 3⅛%
Affected by right vagal pressure	3
Affected by left vagal pressure	2
Pressure on both sides	3
Pressure on right side only	2

As far as effect by age-groups is concerned, vagal pressure seems to be more effective with the advance of years, as will be seen by the following table:

AGE GROUPS

Ages	Cases	No Effect	Change	Percent.
1-10 years	5	3	2	40
10-20 years	19	13	6	31 ½
20-30 years	25	10	15	60
30-40 years	30	13	17	56 2/3
40-50 years	34	12	22	64 2/3
50-60 years	26	9	17	65
60-70 years	19	6	13	58 ½
70-80 years	2		2	100

Eight cases of auricular fibrillation appeared in this series of 160 cases, right vagal pressure being effective in 4 cases or 50%, while left vagal pressure was effective in over 85%, as shown by the following table.

EFFECT OF VAGAL PRESSURE ON CASES OF AURICULAR FIBRILLATION

Age Groups	No. Cases	Before Pressure	R.V.P.	L.V.P.
1-10	1	100	90	90
30-40	1	120	120	120
			for short period	80
40-50	2	120	100	100
		135	90-1 P.B.	100-1 P.B.
50-60	1	100	100	80
60-70	3	80	80	60
		120	80	
—		80	80	

Cardiac standstill 2 2/5 seconds.
Not affected by right vagal pressure 50%
Not affected by left vagal pressure 14 2/7%

As for other effects being produced, in Case 1530, after right vagal pressure, a downward deflection of the P-wave was noted in the third and fourth beats after pressure, due to displacement of the pacemaker. In Case 2020, disappearance of the P-wave was noted after both right and left vagal pressure, this lasting but for two or three beats at a time. In Case 1954, flattening of the P-wave was noted but the

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string was never absolutely isoelectric. In Case 1410, both the taking of a deep breath and right vagal pressure were effective in slowing the cardiac rate and decreasing the voltage of the P-wave. In Case 3032, after left vagal pressure, the third P-wave was not followed by any ventricular complex.

In Case 1003, complete heart-block was effected by right vagal pressure. In Case 1640 of bundle-branch block, after right vagal pressure, a premature ventricular systole appeared, taking the place of the two normal beats. In a case of heart-block which has been under observation for a long period, in which the P-R interval is almost constantly 8/25 of a second, slowing was produced by left vagal pressure but the P-R interval was unchanged, nor was there any change in the complexes. Right vagal pressure was ineffective on the rate and the P-R interval remained unchanged.

In cases where cardiac standstill was produced, in some the P-wave appeared before pressure was released and was followed by normal ventricular complexes, while in others, Case 1966, the ventricular complex appeared without any preceding P deflection, then a P-wave appeared, pressure still being continued. In Case 2082, pressure being continued, a P-wave appeared 4 3/5 seconds after the beginning of pressure; pressure being released soon after, an R wave appeared 1 3/5 seconds later than the P-wave, ventricular standstill amounting to 6 seconds. In Case 2077, cardiac standstill was existent 4 seconds as a result of left vagal pressure, normal complexes appearing almost immediately on release of pressure.

CONCLUSIONS

Vagal pressure should not be applied simultaneously to both vagi. There is no evidence in these clinical records that right vagal pressure is more effective on the sinoauricular node than left vagal pressure. In general, left ventricular pressure is more effective in slowing the heart than is right vagal pressure. When this is produced by left vagal pressure, there is usually no change in the P-R interval. Right vagal pressure was used in the only case where complete heart-block was produced by vagal pressure.

VITAMIN D PREVENTS RICKETS BY KILLING BACTERIA, IS CLAIM

Rickets is fundamentally a bacterial disease, caused by the poisonous products of bacteria in the digestive tract. Vitamin D prevents this distressing ill of childhood primarily by killing off a large proportion of these harmful micro-organisms. These claims, differing radically from the concepts now orthodox in physiology, were advanced at the annual meeting of the American Chemical Society by Lester Yoder, chemist at the Iowa Experiment Station.

Mr. Yoder was led to his conclusions by a study of the bacterial population of the intestinal contents before, during and after the administration of vitamin D. While his experimental animals were receiving the vitamin the bacterial count fell off markedly, but increased again when the vitamin was discontinued. For this reason the Iowa chemist suggests the possibility of using vitamin D as a means for the general control of the bacterial growths within us, as well as for the specific cure or prevention of rickets.

Studies on vitamin D in the test-tube as well as on its physiological effects have confirmed Mr. Yoder in his opinion that it exerts its principal effects without ever leaving the digestive tract. Pure ergosterol, which is the stuff that becomes vitamin D when ultraviolet light has shown upon it, is almost insoluble in water, he said. After exposure to ultraviolet radiation it becomes even more insoluble. In this condition it would be extremely difficult, if not impossible, for it to pass through the intestinal wall and be absorbed into the circulating blood. For this reason the experimentor concluded that it exerts its chief influence in its passage through the digestive tube, not in the circulatory system.—Science Service.

DIET IN TUBERCULOSIS

In order to get accurate and up-to-date information on diet in tuberculosis and to present the matter of feeding the tuberculous patient in a plain and practical way available for general practitioners, John B. Hawes, 2d, Boston, wrote personal letters to 40 or 50 men in this country, each one a well known specialist on this subject, asking eight questions. He received 36 excellent and detailed answers. Summarizing the opinions of these physicians, including his own, in regard to diet in tuberculosis, it is fair to conclude that: Lunches between meals are rarely advisable. The average patient enjoys his food more and takes a larger amount of nourishment when he confines himself to three good meals daily than in any other way. Eggnogs in any form at any time are "an invention of the devil." Raw eggs, if easily borne and if the patient is underweight, do not do any harm and may do good. They are not so digestible as cooked eggs and on the whole are rarely indicated. About one quart of milk daily, four or five glasses, with meals, is the maximum amount that should be given. A glass of milk with each meal is usually sufficient. There are no special foods that need be emphasized. Fruit and colored vegetables will help correct constipation; they contain vitamins but little if any nourishment. Potatoes, macaroni and rice contain much food value. The bowels should act at least once daily. A mild laxative once a week is often a valuable help if a diet with plenty of roughage is not enough. Five or six glasses of water daily is advisable. A rest before and especially after each meal is essential. The dictum "Approach and leave each meal in a rested condition" is an exeremely good one to stick to.—Journal A. M. A.

THE WHY OF BUTTERMILK FEEDING*

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While acid milk is gaining in favor for infant feeding, many are not yet using it. It is thought that a restatement of the reasons why, may lead others to try this most satisfactory food.

For the babe denied his natural supplies, there are offered numerous and clamorous proprietary substitutes, each of which would seem to resemble breast milk more closely than breast milk resembles itself. Yet somehow they often fail to agree with the one infant in whom a frantic family is interested. These advertised foods are all so expensive that even where physically a success, they may be financially a failure.

What most of us want is an inexpensive food that even a sick baby can digest. It is obvious that to do the infant any good, he must be given enough food, and it must digest. But gastric digestion can occur only when the stomach contents are acid. And while the healthy infant has enough acid available to acidify a stomachful of breast milk, the trouble is that its common substitute, cow's milk, requires *three times as much acid,* which friend babe does *not* have, hence ye belliake. That's why we all dilute it for him, that he may have the solace of a full, yet *sufficiently acid* stomach.

And diluted milk usually is satisfactory, in health. But there are times when it will not do. In malnutrition cases, as Marriot points out, the calory requirements are based on what the babe *should* weigh, whereas his digestive capacity is not even up to what he *does* weigh. In such cases a more concentrated food is absolutely vital. So, instead of filling half or two-thirds of his stomach with water, by dilution, we may give him his fill of full-strength milk and lend him acid enough to make it digestible. It works well, both on paper and in babies.

This reluctance of cow's milk to become acidified is not due to alkalinity, since it is actually more acid than breast milk, but is due to what are called buffer substances present. Buffer action is a sort of chemical obstinacy, a stand-pat attitude, a refusal to become acidified.

Chart one, (from Marriott and Davidson)[1] makes apparent this buffer action

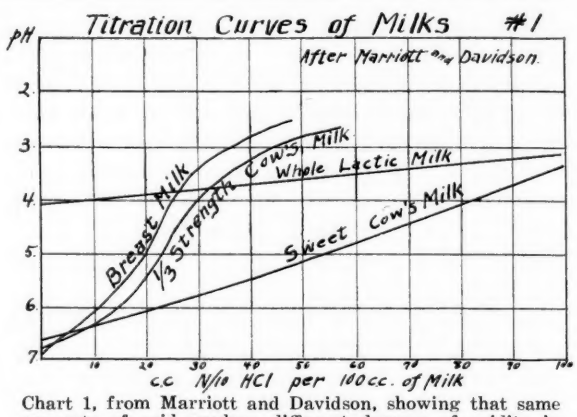

Chart 1, from Marriott and Davidson, showing that same amounts of acid produce different degrees of acidity in different milks, due to variations in buffer content. This buffer action is more obvious when same curves are plotted on an arithmetical instead of this logarythmic scale: see shart 2.

as affecting acidities produced when acid is added to different milks. Degrees of acidity are here expressed by hydrogen ion concentration, designated by the symbol "pH", all of which is doubtless clear enough to the initiated but somewhat mythical to the rest of us. Enough said that pH1 is approximately the acidity of N/10 HCl, pH2 of N/100, and pH3 of N/1000, pH7 being neutrality. But it is

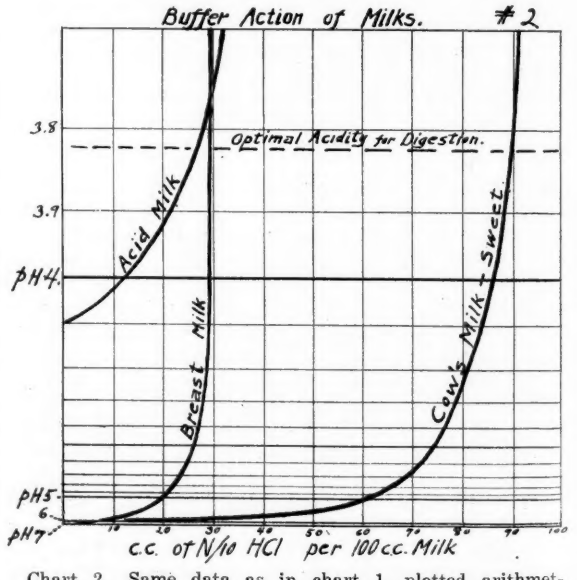

Chart 2. Same data as in chart 1, plotted arithmetically, making buffer action more conspicuous.

1. Marriott, W. M., and Davidson, L. T., "Am. Jour. Dis. Children." Dec., 1923, vol. 26, p.542-553.

*A demonstration presented before the Mich. State Med. Society, Detroit, Sept., 1928.

** Dr. Duffie is a country doctor in north Michigan, who delights in simplifying technical themes. His "Book for Us Diabetics," reviewed in our October issue, is an entertaining version of modern diabetic treatment, comprehensive even to the uneducated. He is a graduate of George Washington (D. C.) '20.

hard for us of the non-mathematical minds to grasp values on this conventional logarythmic chart, and to realize that each successive horizontal line represents *ten times* the acidity of the line below it.

I have therefore re-drawn this chart (No. 2) to an arithmetical instead of the geometrical scale, such that equal distances on the chart represent equal differences in acidity, at all levels. Such a plotting makes the buffer action (the sag in the curve) more obvious.

So much for differences in vitrio. Now for differences "in baby". Chart three,

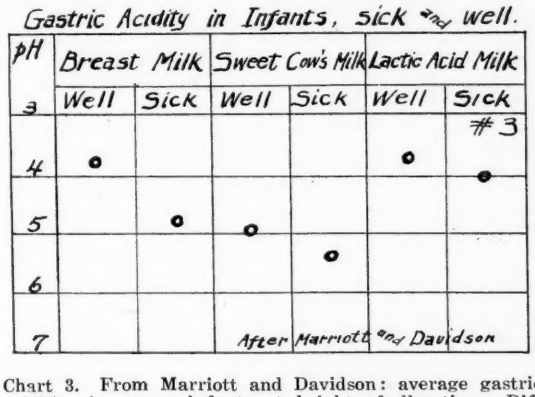

Chart 3. From Marriott and Davidson: average gastric acidities in young infants at height of digestion. Difficult for one not conversant with pH values to realize the enormous difference between first and second columns.

also from Marriott, shows acidities found at the height of digestion in the stomachs of young infants, in different states of health and with different milks. This chart also becomes more eloquent to those of us who are not highbrow, when re-drawn

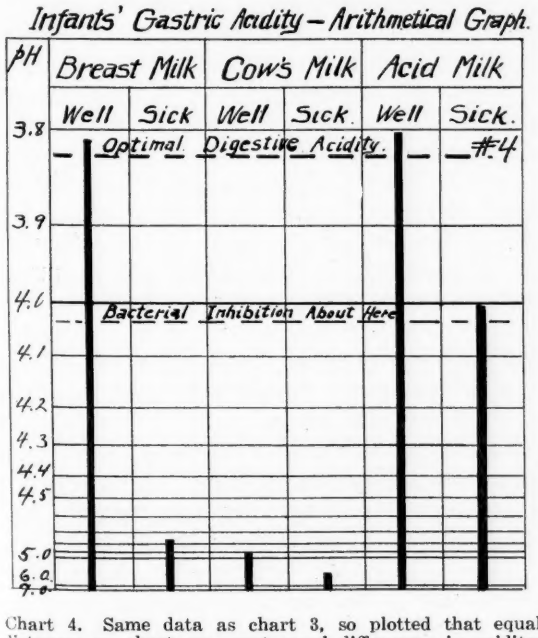

Chart 4. Same data as chart 3, so plotted that equal distances on chart represent equal differences in acidity. Shows an advantage of acid milk over breast milk in illness, both as to digestibility and inhibition of bacterial growth.

to an equal-parts scale, as in chart 4. The points of interest here are that even in healthy infants, the acidity of undiluted cow's milk is much lower than that of either breast or acid milk, while in the *sick* infant, acid milk is the only one that at all approaches the optimal acidity for digestion. This may explain why acid milk often agrees with a sick baby better than does breast milk. In fact, when acid milk fails to digest, we may suspect a parenteral infection, often an otitis.

Another advantage of lactic acid milk is that whereas sweet milk is such favorable culture medium for pathogenic bacteria that it must be kept on ice and is commonly taboo in all diarrheas and dysenteries, the pH of *acid* milk is so inhibitory to bacterial growth that it is practically self-sterilizing, and may be successfully fed to babies in all types of diarrhea—a far cry from the old "diet" of castor oil and barley water!

Cultured lactic acid milks may be bought in any city, and require only the addition of carbohydrate, of which the lowly Karo syrup (dark) is fully as satisfactory as the fancy maltose mixtures. Where cultured milks cannot be bought, acid milk can be easily made at home. A pint of milk is brought to a boil, strained, and chilled cold. 3 cc (2/3 teaspoonful) of lactic acid is added to the desired amount of corn syrup, mixed, then the mixture stirred very slowly into the chilled milk. That's all. The nipple is enlarged with a knife as necessary to let the thick milk through.

Marriott advises a four hour interval, feeding the same quantities as of breast milk (all the baby will take).

MOST FOOD POISONINGS CAUSED BY MEAT

Meat and meat products are responsible for most food poisoning outbreaks, members of the American Public Health Association were told at their recent meeting at Minneapolis by Drs. Thomas G. Hull and Lloyd Arnold of the Illinois State Department of Health and the University of Illinois College of Medicine. When much meat is eaten, the bacteria normally found in the small intestine, where meat is chiefly digested, are disturbed, the doctors explained. The germ-killing action normally occurring in the small intestine is interfered with for six hours after a meat meal. Thus when germs are taken into the system with a meat meal, they have a good chance to develop and cause illness.

Material containing a germ frequently implicated in food poisonings will produce irritations of stomach and intestines when it has been added to fresh meat, but no poisonous effect can be seen when the same material is added to a bread and milk diet, the scientists declared. — Science Service.

THE EARLY DIAGNOSIS OF EXOPHTHALMIC GOITER*

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According to H. S. Plummer's two-product hypothesis of exophthalmic goiter, the unknown stimulus which acts on the thyroid gland during the course of the disease results in the production and delivery to the tissues of an abnormal thyroid secretion, and, in nearly all instances, of an excessive quantity of normal thyroxine. The characteristics of the disease may be readily correlated with this hypothesis. Almost always there are evidences of hyperthyroidism which are identical with the phenomena associated with feeding excessive quantities of thyroid extract, and there are also other phenomena which are characteristic of exophthalmic goiter but are not seen in cases of hyper-functioning adenomatous goiter, nor in cases in which excessive quantities of thyroxine have been administered. The latter characteristics are: (1) exophthalmos; (2) stare (which may or may not be associated with exophthalmos); (3) characteristic psychic status of the patient; (4) frequent, useless, purposeful movements, and (5) gastro-intestinal crisis with diarrhea and vomiting. Any effort to diagnose exophthalmic goiter more accurately must come from a study of these characteristics and of careful and repeated observations of patients, with the characteristics in mind.

Exophthalmic goiter is a common disease in the United States. Pemberton has pointed out that patients with this disease are consulting physicians in increasingly earlier stages of the disease. It is also probably true that the condition is being recognized earlier throughout the country. This is of the greatest significance from the point of view of the disability caused by the disease. The results of treatment are much better in the early cases, and the surgical mortality is considerably less if the patient is operated on early in the course of the disease. Although degenerative changes may not be demonstrable, if the hyperthyroid state has lasted for a considerable period, experience has shown that the surgical mortality is higher. Moreover a prolonged period of disability prior to the institution of surgical procedure directed toward control of the disease is no longer necessary. The use of compound solution of iodine (Lugol's solution) has not only reduced the surgical mortality to less than 1 per cent, but has eliminated the necessity for time-consuming preliminary procedures such as injections of hot water and ligation of arteries.

The typical case of exophthalmic goiter presents such striking signs that it is not difficult to make a diagnosis. In many cases, the diagnosis may be made at first sight. The common picture of extreme nervousness, frequent movements, exophthalmos, stare, tremor, and excessive sweating which are so obvious in many severe cases are so familiar that they do not need emphasis. In the early case these phenomena may be so vague that they may be easily overlooked. There are certain signs and symptoms which always call for an investigation of the function of the thyroid gland. Any unexplained loss of weight, especially if it occurs simultaneously with a normal or increased appetite, should at once suggest the presence of hyperthyroidism. Increased pulse pressure in the absence of aortic insufficiency is a significant sign and always indicates an investigation of the thyroid gland. Demonstrable loss in strength is a symptom which may be easily overlooked. This is best noted when the patient mounts the step of the examining table; the loss of strength in hyperthyroidism frequently is so marked in the quadriceps muscles that women who have been doing all their housework will have difficulty in stepping on the high step. Tachycardia occurs so frequently and in such a variety of conditions, including nervous exhaustion, that it is of less significance than the foregoing signs. However, if it is constant, it should be considered in the diagnosis of hyperthyroidism.

Two groups of emergency cases are of particular importance as regards the thyroid gland. These are so easily overlooked that hyperthyroidism should be considered as a routine concerning any patient who

*Read before Upper Peninsula Medical Society, Ironwood, Michigan, August 7, 1929.

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presents evidence of severe gastro-intestinal or of circulatory disturbances which are not readily explainable on some other basis. Patients may be in the gastro-intestinal crisis of exophthalmic goiter, and in their seriously prostrated condition other suggestive signs may be absent. Many patients with cardiac decompensation are suffering from hyperthyroidism, and, in fact, it is frequently the latter condition which overloads the heart to the point of producing decompensation. Certainly, in many such cases in which there has been considerable organic injury to the heart relief of hyperthyroidism is followed immediately by restoration of cardiac compensation. Occasionally patients in diabetic coma will not respond as expected to the usual procedures, and in a few such instances the administration of iodine either by way of stomach tube or by proctoclysis will result in clearing of the coma. In all of the foregoing emergencies iodine should be administered if hyperthyroidism is suspected, although a definite diagnosis may not be possible at the time. By this plan, the lives of some patients who would otherwise have succumbed to unrecognized exophthalmic goiter will be saved.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis of exophthalmic goiter may offer many problems. It may be very difficult to distinguish it from hyperfunctioning adenomatous goiter. The particular importance of such differentiation is that if the patient has exophthalmic goiter iodine must be administered before surgical procedures are instituted. Therefore, in all doubtful cases it is well to give iodine for a time before operation. The presence of an adenoma in the thyroid gland of a patient in a hyperthyroid state is not evidence of hyperfunction of that adenoma. In from 20 to 25 per cent of the exophthalmic goiters seen at The Mayo Clinic adenomas are present in the gland. The absence of adenoma in the presence of hyperthyroidism is *prima facie* evidence of exophthalmic goiter. One must be sure, however, that the adenomas are not situated below the sternum, in a position in which they cannot be palpated. The characteristic differences between the two diseases, as already noted, constitute the chief points of differential diagnosis. A history of definite crisis also indicates exophthalmic goiter. Bruits over the gland are common in exophthalmic goiter; only those bruits caused by pressure or referred from the aortic area are heard in hyperfunctioning adenomatous goiter. Undermined nails with turned up edges are frequently seen in exophthalmic goiter and rarely seen in hyperfunctioning adenomatous goiter.

Nervous exhaustion may be a difficult factor in the differential diagnosis since the nervous manifestations of fatigue may simulate rather closely those of mild hyperthyroidism. Of course, the two conditions frequently exist simultaneously in the same patient. Patients who are nervously exhausted not uncommonly have elevated metabolic rates because of their inability to relax sufficiently to take the test under "basal" conditions. In the presence of neurosis without hyperthyroidism frequent repetition of the test will usually result in a fall to a normal level. This, however, does not always occur, and in these cases a determination of the effect of the administration of iodine is of value. This procedure is, indeed, of great value in many cases of all types in which exophthalmic goiter is suspected. If the diagnostic criteria of the disease are so mild or so masked as to preclude a positive opinion, careful observation during a period in which iodine is administered often will clear up the diagnosis. The most striking change following the use of iodine will be the disappearance of the stare, the characteristic psychic state, and the characteristic movements. It is usually necessary to give iodine for seven or eight days to establish this change. Change in the basal metabolic rate is also of significance, frequently of particular significance, because none of the other expected changes is measurable. Before giving iodine to determine its effect, basal metabolic rates must be taken repeatedly until they remain constantly at the same level. Training in taking the test frequently causes sharp drops in the reported result. After a constant level is reached, a further drop as a result of the administration of iodine is strong evidence of exophthalmic goiter. Further evidence may be obtained by stopping iodine. The patient with exophthalmic goiter will then show a rise in basal metabolism with a return of the characteristic phenomena of the disease.

Patients with essential hypertension frequently present many manifestations of hyperthyroidism, including increased basal metabolic rates. Rest in bed in such cases will occasionally result in normal metabolic rates. The effect of iodine also

is of some value in the differential diagnosis, but of less value than in cases of nervous exhaustion. It is often necessary to put these patients to bed in a hospital and obtain daily basal metabolic rates for several days before the true metabolic level can be determined. In a few instances in which the patient probably is not primarily in a hyperthyroid state, even such a procedure may not result in obtaining accurate basal metabolic rates. If such patients have considerable adenomatous tissue and the hazard of operation is not too great because of the general condition, thyroidectomy is advisable. Prolonged observation, especially in conjunction with the determination of the effect of iodine, and of the effect of stopping iodine, will usually give sufficient evidence on which to establish a diagnosis. Essential hypertension alone, — however, may produce a constant and considerable elevation of the basal metabolic rate. I have seen one patient with essential hypertension and hyperfunctioning adenomatous goiter whose basal metabolic rate was more than +90 per cent. Four weeks after the hyperthyroidism had been relieved by thyroidectomy the basal metabolic rate continued to be +45 per cent.

Patients with cardiac decompensation sufficient to produce dyspnea will have increased basal metabolic rates. Willius and Boothby have demonstrated the fact that this increase is due solely to dyspnea. As soon as dyspnea disappears under appropriate treatment the basal metabolic rate falls to normal except in cases in which there is hyperthyroidism. It is, of course, important to know in all cases whether hyperthyroidism is associated with cardiac decompensation. Often the patient does not show evidence of enough cardiac injury to explain the decompensation. Increased pulse pressure may be the most suggestive sign. Unexpected loss in weight before the development of edema should make one suspect hyperthyroidism. If the diagnosis cannot be made definitely, safety dictates that iodine should be given until the patient is out of danger, after which the function of the thyroid gland should be studied more leisurely. Auricular fibrillation suggests the presence of hyperthyroidism; in The Mayo Clinic the latter has been found to be the most common cause of auricular fibrillation. Such comparative frequency is not true in many other clinics in which rheumatic disease of the heart is observed much more commonly than the hyperthyroid states.

Patients with parkinsonian syndrome often have a warm, moist skin and staring expression suggestive of hyperthyroidism, and the association of the two conditions is seen not infrequently. Usually historical evidence, absence of loss of weight, normal pulse pressure and the absence of any other physical evidences of hyperthyroidism are sufficient to rule out hyperthyroidism. In some instances, however, this cannot be done easily. The basal metabolic rate is usually elevated because of the tremor and increased muscular tonus of the patient with paralysis agitans. Often rest in bed, particularly rest and the administration of hyoscine, are sufficient to establish reliable metabolic rates. Determining the effect of iodine may be of value in this group of cases. In the absence of all clinical evidences of hyperthyroidism, a basal metabolic rate elevated to +20 and +30 per cent is not unusual, particularly in late cases in which the tremor is marked and extensive.

The occurrence of exophthalmic goiter in children should be mentioned. Although the condition does not occur as often as in adults it is not rare. The disease may not be severe enough to cause loss of weight, but may prevent a consistent gain in weight. The enlargement of the thyroid gland may be so slight as not to attract attention. The diagnosis must often be made from clinical evidences alone, since the most widely used standards for the estimation of the basal metabolic rate may not give a true measure of the status of children. The determination of the effect of iodine may be of great value in these cases. Bruits over the thyroid gland are not definite evidence of exophthalmic goiter since there may be bruits over a vascular colloid goiter. The consistence of the gland in this state is usually much softer than in exophthalmic goiter. Weakness may not be demonstrable. Careful and repeated observation will usually reveal to the examiner some of the definite signs of the disease, particularly stare, characteristic movements, tremor, and hyperemia of the skin. The state of the pulse pressure is of particular value in such cases. The determination of the effect of iodine may offer the most conclusive evidence in this group.

SUMMARY

The early diagnosis of exophthalmic goiter is of great importance, (1) in order to avoid long periods of disability, (2) so that treatment may be instituted at a time when the surgical risk is at its lowest, and (3) to prevent the serious and permanent after-effects of the disease.

ENCEPHALITIS IN CHILDHOOD*

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It has been matter of comment in many of the large pediatric clinics in recent years that the number of cases with severe encephalitic or meningo-encephalitic symptoms is very much increased. These cases offer a considerable problem, on account both of difficulty in differential diagnosis, and of the potentiality of grave after-effects from any form of true encephalitis. We are all familiar by now with the sad story of epidemic encephalitis, its many fatalities and its unfortunate sequels in the form of spastic paralyses, Parkinsonian syndromes, arrested development or imbecility, epileptiform states, and remarkable behavior changes coming on sometimes long after apparent recovery; which make it one of the most to be dreaded of all the diseases with which we deal. This disease, which was epidemic for a time shortly after the war, seems still to be with us in an endemic form, and accounts for a moderate proportion of the cases which trouble us. Another infectious type, more highly fatal, and more sure to be followed by serious effects in non-fatal cases, is the hemorrhagic encephalitis, which, fortunately not very common, has been observed in most of the clinics. A meningo-encephalitic picture resulting from extension of middle-ear or mastoid infection in young children seems to have been observed more often in recent years than formerly. A true infectious encephalitis associated with or following close upon such infections as measles, mumps and chicken-pox, seems to be definitely more common than it used to be—possibly because these diseases predispose to infection with the virus of the epidemic form, for which it would seem that there must be many carriers. This type acts very much like the mild cases of the epidemic form, in that it is often recognized only by its sequels.

We are beginning to realize that careful history taking will often bring to light an apparently insignificant illness in the early months of life which may well have been the cause of an existent spastic paralysis and mental deterioration rather than the birth injury which we should otherwise suspect; while in the older child similar paralyses or startling behavior changes may be traced back to a like, apparently trifling cause. These forms, all true infections of the encephalon, make up a considerable, but not the greater proportion of the group of cases which I wish to consider. The larger part consists of varying manifestations of the symptom-complex variously known as "serous meningitis," "wet brain," meningismus," or "toxic encephalitis" or "meningo-encephalitis." "Wet brain" or cerebral edema is perhaps really the best designation for these, as the varying symptom-complex seems to depend upon an edema, localized or general, of the brain and its meninges, due to circulating toxins of various infections. These conditions have long been recognized. They range from the temporary convulsive or comatose states of beginning otitis media or pneumonia or other acute infections to prolonged and alarming cerebral disturbance in such diseases as pyelitis. A group of toxic cases of another kind is to be added to these: viz., the lead encephalitis which has been a number of times observed in babies who gnaw the paint off beds, etc.

There is no doubt, I think, that these forms of "toxic encephalitis" are engaging our attention much more now than formerly. This is, of course, due partly to anxiety over possible true encephalitis, and our desire to make accurate differential diagnoses and correct prognoses. I am sure, however, that the conditions are actually more common. There is no obvious reason for this, and we can only assume some unexplained change in prevalent types of infection.

As I have intimated, our main interest in these toxic forms lies in the questions of differential diagnosis, and here we have to consider not only the types of true infectious encephalitis, but the different meningitides, especially the tubercular and luetic, as well as those due to pyogenic organisms; and the cerebral type of poliomyelitis. So far as symptomatology goes we have no very definite criterion. When meningeal irritation is a prominent feature the resemblance to meningitis is very close; while when the en-

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cephalon is chiefly involved we have a very definite encephalitic picture. In infants and young children the involvement of the cranial nerves so striking in epidemic encephalitis, is not so readily observed. The character of accompanying infections has an important bearing on diagnosis and prognosis. In the presence of pneumonia, otitis media, tonsillitis, and pyelitis, symptoms of cerebral involvement, especially if they appear early, are likely to be toxic, though pyogenic meningitis must always be kept in mind. Usually, in these diseases the early cerebral manifestations disappear rather quickly, though in pyelitis, which seems especially prone to cause severe disturbance, amounting at times to prolonged coma, it is not uncommon to see them subside slowly as the primary infection clears. The late appearance of cerebral symptoms in or after chicken-pox, mumps, measles, or sometimes whooping cough, is more likely to be indicative of a true infection of the encephalon, as are the mental degeneration and character changes appearing after apparently insignificant brief illness.

Ordinarily, of course, our main diagnostic reliance is a study of the cerebrospinal fluid. Unfortunately, it is often a broken reed. Cultures positive for the meningococcus or other pyogenic bacteria, the finding of tubercle bacilli, or a positive Wassermann test, are of course diagnostic for meningitis. The hemorrhagic encephalitis has a bloody fluid with high cell counts. The cell count ordinarily is ambiguous. At first we supposed that high cell counts implied definite infection; but we have observed counts running into the hundreds, and sometimes into the thousands in cases quite obviously dependent on such a primary infection as pyelitis and clearing entirely as it improved. On the other hand epidemic encephalitis has characteristically a low cell count. Sugar determinations have not helped us in differentiating toxic from true encephalitis, though they are of use at times in distinguishing from tubercular meningitis. The sugar content in encephalitis is likely to be rather high, while in the meningitides it is below the average, and in tubercular meningitis becomes progressively lower. The results of globulin tests have been with us very inconclusive. They are more generally positive in true infections. We have not made routine studies of the chlorides.

Blood counts also are unreliable. In toxic encephalitis the count is determined by the character of the primary infection, and has a wide range. True encephalitis and poliomyelitis show a moderate leucocytosis. Tubercular meningitis may have a low count, but leucocytosis in early stages is common. The pyogenic meningitides have moderate to high white counts.

Eye ground examinations have a certain value, especially in the occasional case where there is strong suggestion of tumor. We have had a few where the distinction was very difficult, and at least two where all of us were wrong. As between the types of encephalitis there seems to be no definite distinction, but true choked disk and atrophy ar not characteristic of the encephalitic picture.

It is still a question with us whether on the one hand true cranial nerve palsies, even though temporary, are more indicative of a true infectious process, and on the other hand, whether permanent damage, such as spastic paralyses, may result from a prolonged toxic syndrome. My personal opinion is that the temporary palsies may accompany toxic forms; but so far I still believe that permanent effects are due only to true infections.

On the whole, it seems to me that we still have no absolute criteria for differential diagnosis between true infections and toxic forms, nor between either of these and the cerebral type of poliomyelitis except microscopic examination of autopsy material. The presence of some one of the infections likely to cause encephalitic symptoms favors the toxic diagnosis: the absence of discoverable foci inclines toward true infection. Severe symptoms of brief duration are more commonly toxic. Looking backward: complete disappearance of all symptoms is more likely in toxic forms, while residual paralyses, behavior changes, etc., indicate an antecedent true infection, even though unrecognized at the time. Season and the presence of epidemics are important in distinguishing poliomyelitis and encephalitis.

I am sorry to offer no definite treatment. Some things, such as salicylates, have been recommended as routine, but reported cases show no real benefit from them. Logically, one should try to minimize intracranial pressure. This can be done by judicious spinal taps, and by hypertonic intravenous injections. In this connection I might say that with our present very free administration of fluids interstitially and intravenously, we may occasionally, if they are not hypertonic,

bring on symptoms of cerebral edema which might lead us to suppose that the patient had developed an encephalitic syndrome in the course of his primary illness.

I have presented this paper mainly to emphasize the frequency and potential gravity of these conditions; and the need for very guarded prognosis in doubtful cases.

DISCUSSION

Dr. David Levy (Detroit): There is very little to add to what Dr. Cooley has said. I merely want to make a point, and that is to crystallize this entity of encephalitis. The term "encephalitis" and particularly the term "toxic encephalitis" are loosely used. I find "encephalitis" is a term used by many men to describe a more accurate knowledge or lack of a more accurate knowledge of what is transpiring in the central nervous system, or the brain. Very frequently we find a diagnosis of encephalitis made because it covers the symptoms, whereas it might have been a diagnosis of brain tumor, brain abscess, poliomyelitis, or tuberculous meningitis.

There is no question that we see these insidious things developing following the apparently minor infections, and it is important to note the fact that the earlier the things occur, the graver is the prognosis. That is to say, the encephalitis of early infancy is most likely to be followed by a dementing change.

A few days ago I had a child of sixteen months which had a perfectly normal history up to six months. At that time it had minor puerperal infection, and since then has made no mental development whatsoever. Of course, the diagnosis is a difficult thing. It is hard to diagnose the deficiency in any child under six months of age. Maybe this was some congenital thing. With such history, as the child having held itself erect at the proper age and sat up, a minor infection having occurred and a subsequent dementing process, it is obvious that something cerebrally occurred at that time.

There was another sad case in which there is the same story, at a little more advanced age than the case I mentioned. The youngster had apparently a minor infection, followed by mucus. The prognosis in regard to these things is bad, according to the age they occur. The earlier the age they occur, the worse, in my opinion, is the prognosis. It is a highly important thing about the subject of encephalitis, because it does occur. Sometimes it is an easy diagnosis to hide behind to the detriment of the patient.

Dr. John P. Parsons (Ann Arbor): I am very glad someone else brings up the point that high cell count is not indicative. I recall a case we had in the ward of a cell count of 2,000. All the patient had was local inflammation of the auris. Dr. Cowey was insistent that we leave the patient alone.

There is one other question I do want to ask Dr. Cooley; perhaps I misunderstood. Is a low spinal sugar indicative of meningococcus? We have taught that, but at the present time we feel that is not true. The last two cases of meningococcus came in rather late, probably the end of the first week. Both had a low blood sugar, as low as .02.

Dr. William S. O'Donnell (Detroit): To bring out Dr. Cooley's point about cerebral edema following the giving of large amounts of fluid, I had a case of very severe diarrhea, in which we used intravenous glucose, 10 per cent, and saline under the skin. After having the case in the hospital five or six days, I noticed the child was losing its sight. I observed it did not notice anybody. The sickness was a little more severe. The child was doing fairly well; had a temperature equal to otitis media. The child was developing something definitely cerebral, although the coma was not the cause of this. I talked the matter over with Dr. Cooley, and he suggested that we were pushing the fluids, and it may possibly have cerebral edema. I had been giving 10 per cent glucose, and I discontinued the saline, and started giving 20 per cent of concentrated glucose with the idea of dehydrating. One tube of 200 c.c. injection of glucose very definitely changed, and brought out this point that forcing fluids too much will cause cerebral edema. The child has gone home entirely well. There is no doubt that for a period of three days the child was not noticing anybody. That is the most striking thing I noticed about the diagnosis; the children do not notice the parents. Whereas they noticed them before, they did not later on.

Dr. T. B. Cooley (Closing the Discussion): Dr. Levy brought up the point that is of a great deal of importance. I am inclined to think that his observation is correct, that the gravity of the after-effect of the child is more or less in proportion to the age of the child.

There is another thing I meant to have mentioned, and that is, I believe early encephalitis is probably accountable for a good many things we have formerly attributed to birth injury or to other congenital conditions, things like definite mental backwardness, certain types of paralysis, and so forth. We have thought, since we began studying this question, that we could trace those back to acute illness in early infancy rather than to birth.

Another thing is the epileptiform. They do not have to result from birth injuries, and I think quite a few are as a result of early encephalitis.

Dr. Levy asked me what I thought about the possibility of the elimination of hexamethylen into the spinal canal having anything to do with the development of the encephalitic state in the pyelitis—with the clearing up. I have no observations that have any bearing on that subject. Most of our patients do not get hexamethylen anyway, and I do not remember seeing any of these cases with the encephalitic syndromes which have had that particular treatment. As a matter of fact, we have not tried it. So I cannot answer that.

Dr. Parsons asked about low sugar spinal fluid. I think it is fair to say that in our cases most of the patients who have shown definitely low sugar as compared with blood sugar have been cases of tuberculous meningitis. We have had other cases. I could not say offhand just which they were. We have had one or two cases of meningitis where the sugar was temporarily low, but I think the lowering of the sugar over a considerable period almost always refers to tuberculous meningitis.

WHAT ABOUT CHRONIC APPENDICITIS?*

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The title of my talk is presented in the form of an interrogation to express the doubt existing in the minds of many as to whether there is any such clinical entity as "chronic appendicitis." Some have called it a myth; others, a misnomer; others still have refused to class it with inflammations or infections, either pathological or clinical. One medical cynic has gone so far as to divide appendicitis into two classes: —"Acute appendicitis and appendicitis for revenue only."

Diametrically opposing views are held by medical men of equally wide standing and experience. Most of these divergencies can be explained by failure to agree upon questions of terminology. Some are dependent upon disappointments in diagnosis. Now and then debate centers around the pathological findings. On the one hand there are surgeons like Whiteford (of Plymouth, England) who assert that the symptoms are not properly interpreted, that the microscope is not to be trusted, that the complaints always persist, that the actual admission of such a condition as a "chronic appendix" produces a looseness of thought on the part of the profession and a loss of faith on the part of the laity, and that "the operation should be abandoned." On the contrary Eastman believes that chronic appendicitis is a clear-cut disease, and no myth; that it exhibits characteristic pathology, that its symptoms though complex are reliable and that removal of the appendix brings cure. Deaver boldly states that "chronic appendicitis is probably the most common of all abdominal diseases," and that, "it is rare for an adult to possess an appendix that is normal in every respect." Agreeing in general, Gaither, an internist, concludes that "chronic appendicitis is a distinct, widespread, often unrecognized malady," to be thought of in every case of abdominal disorder.

Pathologically the case has been stated by Aschoff: there is no such condition as an original chronic inflammation of the appendix and what seems to constitute this affection is a left-over from previous acute inflammations. He found a diseased appendix in 75 per cent of all cases examined. By certain observers these laboratory considerations are regarded as purely academic. "Pathologically," in the words of Watkins, "the chronic appendix is an end result and not an active process."

My personal position lies in the midground between the extremes of those whose opinions I have just outlined. Undoubtedly there is a clinical manifestation produced by a continuing process in the vermiform appendix, no matter what its origin, pathology or signs. If the word "chronic" means anything at all, it signifies of long duration and here it may imply either constant symptoms or recurrent paroxysms. Much confusion has come from different phases of the condition being grouped under one head. In general there are three types which are classed as chronic appendicitis: (a) resulting from an acute appendicitis, arising in one attack and going on as a chronic affection with no other acute attack; (b) existing as repeated attacks of mild type at more or less frequent intervals; (c) running a chronic course from the beginning without acute attacks. The first two are referred to by many observers as "relapsing" or "recurrent"; the third type is the variety whose symptoms are most vague and whose existence has been questioned.

It is quite impossible to lay out any detailed *symptomatology*—there is none. For the most part the patients suffer from "stomach trouble," pain, gas pressure and indigestion. This syndrome was strikingly referred to as "appendicular dyspepsia" by Longuet who first described it in 1902. He attributed the symptoms to three types of derangement: mechanical interference with the intestine, due to stasis; reflex disturbances, seen chiefly in pyloric spasm; toxic absorption from the appendix, exhibited in the general systemic signs. The third item would not obtain in the fibrous, obliterative variety.

There is sufficient evidence, however, to show that the appendix is often the focus of disease manifesting itself in other parts of the body. The tonsils and the teeth have held the boards rather conspicuously.

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Some years ago I proposed an alliterative slogan of homely nature to cover additional foci. I suggested the three T's—Teeth, Tonsils, Tummy. The latter means the abdominal cavity and includes the appendix, the gallbladder, the prostate in men, the pelvic organs in women, the kidney and the intestinal canal. The vermiform appendix as a primary focus has not been given due attention. Cases of cure of chronic arthritis, neuritis, and other allied affections following appendicectomy are being reported, when the appendix was often not suspected until an acute flare-up occurred. This leads to the assertion, which I have insisted upon repeating in season and out, that in appendicitis the attack is not the disease, but only a knock at the door; that the condition is a continuing pathological process, a "going concern," producing its damage between times and always diseased before an attack can occur. This must be assumed from observations made when operating for acute appendicitis, where within a few hours after the initial pain there are found perforation with gangrene and adhesions—and yet no history of a previous attack. All of which could hardly have happened in six hours or even overnight. Obviously in such instances the appendix had been the seat of disease for a period of time, even though little or no clinical signs existed—certainly not of a localized character.

If one should demand, then, an orderly array of symptoms attached to the condition called chronic appendicitis, it would be impossible to supply them. Special considerations must be given to the protean character of the complaints, to their irregularity as compared with signs of other abdominal affections. I am conscious of no more perplexing *diagnosis* in the realm of medicine. It can be made intelligently and honestly only by a process of exclusion, by ruling out all complicating elements, and finally indicting the appendix upon the clearest circumstantial evidence. It must be held innocent until proved guilty. A complete and discerning history is the first step. The talent of a detective is needed to uncover the memory of a long-ago forgotten attack or the possibility of vague abdominal symptoms in childhood leading to an unsuspected early infection of the appendix. Physical examination is concerned chiefly with a study of the abdominal reflexes; with a realization that the disease is most often where the pain is not and that pressure-tenderness is extremely unreliable. There are a number of so-called "signs"—I have listed fourteen, to be exact—which may or may not be helpful. Their interpretation unfortunately depends too much on the personal equation both of examiner and patient. Pain, either subjective or objective, in the right iliac region alone raises a presumption against chronic appendicitis. Special examinations are indicated: the eyes, the nose and throat, the stomach contents, the blood, the stools, the urine, —all should be investigated. The cystoscope may be needed. The value of a thorough roentgenological survey cannot be questioned. Its aid, however, is more in the way of furnishing indirect, rather than direct, information. A flat film is needed to exclude calculi in the urinary tract, while the routine use of an opaque medium is of assistance in elucidating other gastro-intestinal lesions. My policy is to regard the roentgenologist as a consultant along with the internist and the surgeon. It will not be necessary here to go into the details of differential diagnosis. Suffice it to say that it is vital to rule out every possible source of the symptoms or to admit any other factor which may co-exist.

Every case of so-called "chronic appendicitis" should be studied in the light of its effect upon the whole human mechanism. Outside of its role in focal infections some consideration should be given to its involvement in certain forms of colitis. Mueller has suggested that frequently recurring, often insignificant, attacks lead to a round-cell infiltration of the appendical wall, which seldom is recognized by the naked eye; but, if the lumen is blocked and drainage interfered with, the usual symptoms occur, absorption of toxic products takes place, and there may supervene the various signs of general intoxication—headache, dizziness, neuralgia, etc. Boas, the internist, refers to the part played by the cecum and the autonomic nervous system in relation to the clinical picture of chronic appendicitis. He admits "that every case of chronic appendicitis was at some time preceded by an acute forerunner" and confesses "that chronic appendicitis is not a pleasant disease either for the surgeon or the internist, because we are not masters of the situation." Haberer, the surgeon, agrees largely with the foregoing, emphasizing the conception that many cases of chronic appendicitis fur-

nish a "part of a genuine colitis, either as cause or effect" and that the condition "actually may be accompanied by chronic appendicitis." Very earnestly he deprecates the rushing in to operate in such cases. "Finally," says Haberer, "there also belong to this group the cases in which the appendectomy is the first step to multiple laparotomies, of which every one, especially the first, had better be omitted." He coins the term "abdominal polypragmasia" as the suitable designation of the practice to which these willing victims are subjected. I join heartily in the choice of the term and in the condemnation of those who perform operations for the removal of the appendix upon hastily considered judgment and incompletely determined data.

Well, what are we going to do about chronic appendicitis? The answer is, diagnose it. It makes no difference what we call the condition or whether we admit its existence at all, the problem, in Connell's words, "deserves serious study before and not after removal of the so-called 'chronic appendix' ". The important warning is to keep away from the fetish of "pain in the side." Looking upon the appendix as a focus of infection is enlightening. One should never fail to give the patient the benefit of removal when the appendix is guilty beyond a reasonable doubt; but we must remember that appendicitis sometimes exists in the imagination of the patient as well as in the head of the surgeon. If the diseased appendix is actually in the belly of the patient, out it should come. "An empty house is better than a poor tenant."

THE FOOT AND THE SHOE

Alfred J. Buka, Pittsburgh, asserts that the shoe must be so constructed that it will meet the hard surfaces on which the pedestrian is compelled to walk. Nevertheless, such a shoe must have a certain flexibility and resilience which shall conform somewhat with that of the foot. Soft leathers are not advocated for service and correct wear. A shoe constructed from vici kid or similar soft leather uppers is not recommended. It loses its contour too readily and does not protect the foot against the hard knocks and bumps of ordinary use. A shoe need not adapt itself to the foot, although soft leathers do this. The shoe built of such leather becomes unsightly and does not afford any upper protection. Corrections which may be required for bad feet are to be applied to a common type of shoe which, in every detail, is considered as being built in the nearest conformity with the foot and with what the natural foot should wear. Calf leather has been used for the construction of the one type of shoe that contributes most to protection and support, combined with comfort and durability. Whatever the shoe may be that is worn, it should always be placed on a shoetree and in a dry place after removal from the foot. Perspiration of the foot is absorbed in the leather of the shoe during wear. The blucher type of upper is used because it helps to pull up the lateral support, which is very much needed for the weak foot and the falling longitudinal arch. It further overcomes binding at the tarsometatarsal articulations. Lateral support is also helped by an extra long counter, which extends almost to the metatarsophalengeal articulation of the great toe. Thus, a tightly fitting adjustment around the longitudinal arch and instep is established. With this particular support and grip there is accomplished what is most to be desired from the upper of any shoe. Close adjustment is brought about through the snug fitting heel by tapering upward the back portion of the counter. Hence the counter at the heel is made a size narrower at the top than at the base. Thus, the shoe is constructed so that when laced there will be practically no pressure anywhere distal to the metatarsophalangeal articulations. This allows for the possibility of freedom of movement of the toes. The inner line of the arch is built so that it is higher than the outer. Another feature incorporated in the model is the extension sole, a flare-out beyond the usual amount on the outer side of the shoe near the metatarsophalangeal articulation. The purpose of this is to support the increased width of the foot during walking and weight-bearing when the transverse arch drops somewhat. The question as to whether a shoe should be of the oxford or the high-top type is a personal one. The oxford is the shoe of general utility. The ideal heel for shoes should be a broad rubber over leather type. A modified Thomas heel is advocated in cases with painful dropping longitudinal arches. In the case of the woman's shoe, the height of the heel should be from 1¼ to 1¾ inches. In the man's shoe the height should be from 1 inch to 1⅜ inches. As most shoes are fit "short," in measuring a foot for shoeing an allowance of from 1½ to 2½ sizes larger should be given to the shoe beyond the actual measurement of the foot during weight bearing. The shape of the shoe is such that in general principle it conforms with the shape of the foot, the inside line being almost a straight line while the outside is a modified swing which most nearly conforms with the swing of the toes. For assurance of ample room at the joint of the great toe, the vamp is cut so that it shall measure a width and a half more than that of the standard width of the shoe, and a half size more through the thickness at the great toe. When laced, this shoe hugs about the os calcis and achilles tendon behind, and does likewise immediately behind the metatarsophangeal articulations back to about the Chopart joint. The foot should rest in the properly fitted shoe with the feeling that there is support during weight-bearing under the longitudinal arch and a binding feeling with comfort and support around the upper of the shoe over the instep. The foot must fit into the heel of the shoe when laced, so that the upper portion of the counter will grip about the insertion of the achilles tendon firmly, yet comfortably. For the generally correct shoe the principle of wedging the inner or medial aspect of the heel about one-eighth inch has been adopted. This amount of wedging should be continued for ordinary wear at all times.—Journal A. M. A.

HEREDITARY FACTORS IN EPILEPSY, AS SET FORTH IN A STUDY OF 1,000 CASES

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This paper is not offered as being an exhaustive study of the subject at hand. Much has been written both for and against the idea that there is a recognizable factor of heredity in epilepsy. Extremely disagreeing statements are expressed in the literature. Some say essential epilepsy is strictly a hereditary problem, while others cannot see any such relationship. Some point out the relatively few cases of epilepsy in parent and offspring and the very few cases of its occurrence in even three generations of direct descendents and conclude that heredity is not an essential factor. Others take the stand that it is not required to set up cases of direct inheritance of epilepsy in order to establish the principle of heredity. They believe that certain neuroses are so frequently represented in the antecedents of the epileptic, as to make them as important factors in the heredity as cases of epilepsy itself occurring in ancestors. They believe that a migrainous ancestry portends epilepsy and hence there is a hereditary factor in that respect. Much of the disagreement in conclusion is due to disagreement in premises.

In this study we are not attempting any conclusions, but are offering a statement of finding as shown in the histories of 1,000 cases of epilepsy from the records of the Michigan Farm Colony for Epileptics. We have undertaken to ascertain the occurrence of insanity, feeblemindedness, and epilepsy in the grandparents, parents, siblings, and collaterals of these 1,000 epileptic persons. We have also included such factors as migraine, alcoholism, and fainting spells, in our tabulations, considering the relations claimed by some for these factors. We have limited this to parents and grandparents however.

Of the 1,000 cases reviewed 443 gave evidence of the existence of one or more of the above enumerated factors. That is 44.3 per cent of the cases have recorded one or more of the evidences to which some students attach significance in determining the role of heredity in this disease.

This percentage is undoubtedly much lower than the real condition is. Our earlier case histories are relatively incomplete and, from personal experience, we realize that oftentimes questions on a printed family history form are not answered seriously, if at all. Personal investigation by a trained agent would, no doubt, put into the histories much of value that is omitted in these cases wherein the family and personal history represents the efforts (more or less conscientious) of some one member of the family to answer a set of printed questions.

We have not undertaken to pick the cases, however, but have taken them just as set forth in the routine family histories on file in this institution.

1. Epilepsy—Perhaps the outstanding inquiry is, "Is there any other case of epilepsy in your family?", upon the answer to which some are quite inclined to conclude that heredity does or does not play a role in the disease.

In the 443 families represented, epilepsy in the relatives occurred 288 times, with the following distribution: 19 fathers, 24 mothers, 24 grandfathers, 25 grandmothers, 83 siblings, and 113 collaterals (uncles, aunts and cousins). This then shows 92 instances of direct family relationships, as represented by parents and grandparents. The records show five instances wherein there were two epileptic offspring from an epileptic patient and one instance of three epileptic children from an epileptic parent.

There were 13 epileptic sons and nine epileptic daughters from epileptic fathers and 10 epileptic sons and 17 epileptic daughters of epileptic mothers. This agrees with the findings of Gerum that more epileptic sons than epileptic daughters are from epileptic fathers, and more epileptic daughters than epileptic sons are from epileptic mothers.

In this group there were no cases in which both parents were epileptics.

2. Feeblemindedness — Feeblemindedness occurred among the parents of these epileptic persons more often than did epilepsy, being present 15 times among the fathers and 44 times among the mothers. This corresponds with the observations of some authors who claim that more epileptic offspring are born to mentally subnormal parents than to epileptic parents. Our study further showed the appearance of feeblemindedness 36 times among the grandparents and 180 times among the

siblings and collaterals, the total occurrence being 275.

3. Insanity—The occurrence of 202 cases of insanity among the ancestry of 443 epileptic persons certainly indicates that mental instability is more marked among the background of these partciular persons than would be found in the families of that many so-called normal persons.

Just how much of this condition is reappeared in the form of epilepsy is a matter only for conjecture. It does show, however, that the members of the family of the average epileptic are not as free from mental impairment, as would be found in the background of the same number of normal persons.

4. Alcoholism—On the subject of alcoholism as a factor in impaired mentality, many have been set forth both attesting to and discrediting its significance. The findings of certain writers on this subject show an increased number of defective offspring born to intemperate parents over those offspring born to the more temperate type. These studies further tend to show the possibility of mental impairment among the offspring from the mating of alcoholic and neurotic parents. Alcoholism in our study was noted 112 times among the parents and 74 times among the grandparents, making a total of 186 instances in 443 cases or 42 per cent.

5. Migraine—The close relationship between migraine and epilepsy has been noted by many writers of articles on epilepsy. It has been declared that five times as many epileptics as feebleminded offspring are due to matings marked by neurotic traits among which migraine is an important factor and that one migrainous parent is as likely to produce an epileptic offspring as is an epileptic parent.

The question as to whether any members of the family suffered from headache is, for the most part, only half-heartedly answered. Upon further questioning it is very often brought out that one or the other parent, and in some instances both parents, suffer from recurring attacks of migraine. Our figures showed the appearance of migraine 77 times among the parents and 16 times among the grandparents.

6. Fainting Spells—The formal "personal and family history" contains an inquiry if any relative is afflicted with "spasms, fainting spells, nervous prostration, hysteria, insanity, blindness, deafness or any other mental or physical defects." It is readily observed that this question is too extensive. It is in the answers to this question that we find the acknowledgment of the occurrence of "fainting spells" among the parents and grandparents 463 times.

We very often encounter people who refer to frank epilepsy as "fainting spells." Also we know that many cases of "fainting spells" are really petit mal seizures. On the other hand there are many cases of "fainting spells" that have no relation whatsoever to epilepsy. In view of this fact, and of the lack of sufficient follow-up study of this detail of our institution histories, we are at a loss even to conjecture the significance of 463 cases of "fainting spells" among the ancestry of our 443 epileptic cases.

We are quite of the opinion, however, that many of these cases should be listed as occurrences of epilepsy in the ancestry and, therefore, that our shown percentage of direct heredity of epilepsy is accordingly too low.

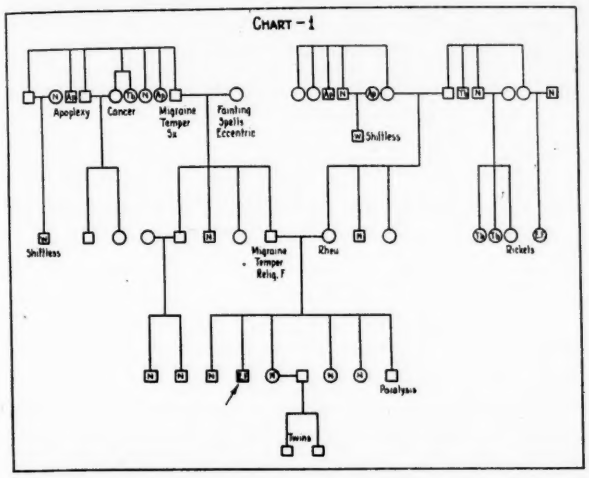
7. Temperous Outbursts—Those family histories, wherein we were able to make direct contact with at least one member of the family, upon close questioning, very often disclosed the fact that among the ancestry there were one or more members given to violent outbursts of temper. In some instances several members of each fraternity in c o n s e c u t i v e generations would be noted. This is quite nicely illustrated in Chart No. 6 shown in this article. It is our contention that, in many instances, these temperous outbursts are unrecognized symptoms of epilepsy, and that they are too closely related to epilepsy to be dismissed without some question as the probability of their being a hereditary factor.

Musken, in his recent writings, states that some authors have observed that many of their patients give a history of periodic attacks of psychical discharge such as paroxysms of rage which, in his opinion, constituted the fit. These attacks, for the most part, disappeared upon the establishment of recognized epilepsy.

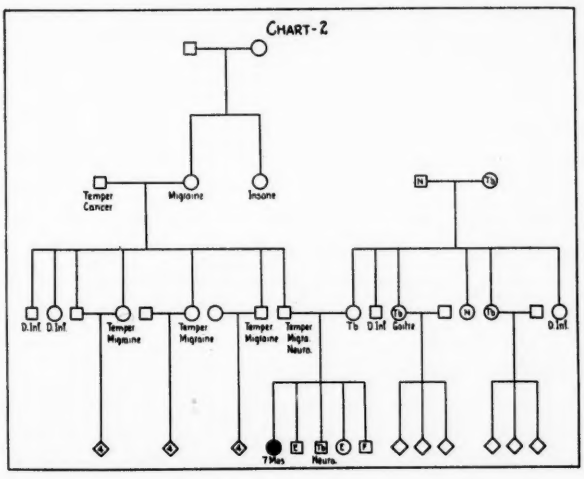
Our data, relating to the occurrence of temperous outbursts, were too indefinite to be of value. In most instances it was charged to the father and paternal grandfather. The monopoly which the paternal side of the family seems to have on ill temper may be explained by the fact that, in the large majority of cases, the family histories are furnished by the mothers.

After having gone into the generalities of the study as shown by the tables, it is rather interesting to go into the family

histories of some of these epileptic patients, illustrating various combinations of what we have styled hereditary taints or factors and bringing out the possible consequences, as shown in the following ancestral charts.



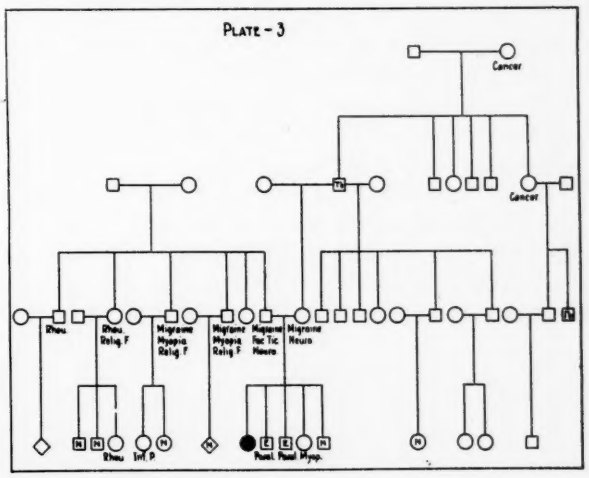
This patient, while coming from a family which would ordinarily be considered as above the average in industry, capability, and mentality, shows a very decided hereditary element, and one which practically portends epilepsy. It is to be noted that the father is given to outbursts of temper; is afflicted with migraine, and is a religious fanatic. The father's mother is noted to be eccentric and subject to fainting spells. The father's father manifested high type migraine and was considered



sexually delinquent. A sister of the paternal grandfather had twin children, one of whom died of convulsions. There was also an impression of shiftlessness in another member of the family. The patient's mother is afflicted with rheumatism and comes from ancestry showing eccentricity and asocial traits; much tuberculosis; one case of feebleminded epilepsy, and at least one case of shiftlessness.

Dr. Week's statement that neurotic ancestry is five times as likely to produce epileptic offspring as it is to produce feebleminded offspring, is nicely illustrated by this chart, showing neurotic traits brought together and culminating in epilepsy.

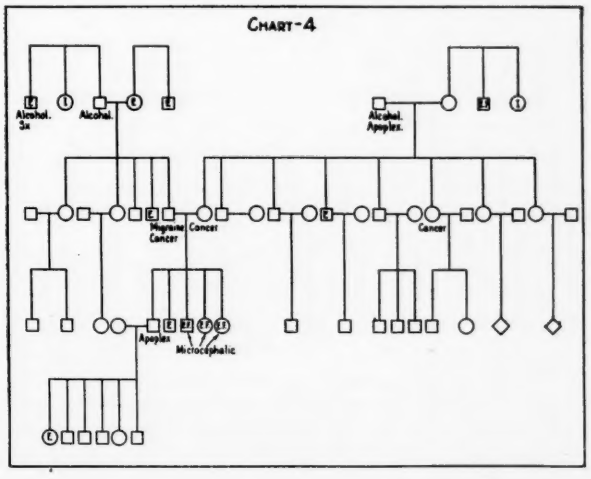
This family history shows the bringing together of a family (paternal) character-



ized by neurotic features, particularly explosive temper manifestations and the occurrence of migraine, with a family (maternal) featuring much tuberculosis, constituting a definitely depleted stock.

The product of this combination is represented by one miscarriage; one epileptic son; another son probably tuberculous; one epileptic daughter, and one feebleminded son.

While this chart does not show, in any



instance, direct inheritance of epilepsy, it is our contention that it does exemplify a very specific hereditary principle, and that it particularly illustrates the fact that a

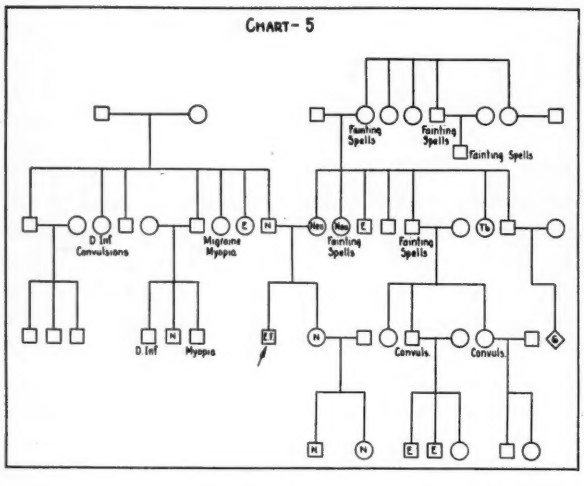
neurotic ancestry is conducive to epilepsy, especially when combined with a family whose stock is, though not necessarily neurotic, weakened or depleted by chronic ailments such as, in this case, tuberculosis.

Portrays a family (paternal) wherein much migraine, myopia, and religious fervor is shown and a maternal family showing tuberculosis, migraine, and myopia. The bringing together of members of these two families in this particular instance resulted in one still birth; one epileptic son; one son who is both physically and mentally defective, and one daughter who suffers from myopia.

This chart shows the ancestry of three epileptic patients of one family, each of whom is also microcephalic.

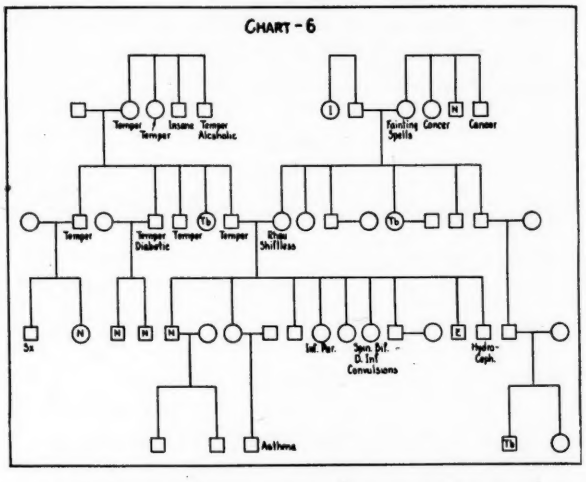
The maternal family featured alcoholism, epilepsy, feeblemindedness, and insanity. The paternal ancestry showed alcoholism, epilepsy, sexual delinquency, temper, and insanity.

CHART - 5



The history of this patient shows us a family where the mother is noted to have strong neurotic tendencies. Occurrence of fainting spells is noted in five instances. Epilepsy, feeblemindedness, hysteria, tuberculosis, and convulsions in early childhood are also in evidence. The paternal family features migraine, myopia, convulsions in childhood, and epilepsy. The mating of two people from such definitely depleted stock, as in this instance, resulted in a feebleminded epileptic offspring.

CHART - 6



In this particular family manifestations of violent temper is the dominating factor in the paternal family. Alcoholism, insanity, sexual delinquency, and family desertion are also noted. The maternal family is characterized as being the shiftless, ne'er-do-well type, featuring feeblemindedness, fainting spells, shiftlessness, and much tuberculosis. The product of this combination, in this particular instance, being one child born with a spinal bifida, who died of convulsions soon after birth; one other child who died in infancy of a condition resembling hydrocephalus; one child physically deformed, and one epileptic son of the most vicious, irresponsible type.

TABLE SHOWING HEREDITARY FACTORS IN RELATION TO 443 EPILEPTIC PERSONS

	Epilepsy	Feeble-minded	Insanity	Sub Total	Alcoholism	Migraine	Fainting Spells	Sub Total	Grand Total
Father	19	15	17	51	104	11	176	291	342
Mother	24	44	17	85	8	65	184	258	343
Paternal Grandfather	11	12	17	40	47	0	53	100	140
Paternal Grandmother	8	4	9	21	0	3	3	6	27
Maternal Grandfather	13	3	9	25	23	0	27	50	75
Maternal Grandmother	17	17	9	43	4	13	20	37	80
Siblings	83	75	33	191	.....	.....	.....	.....	191
Collaterals	113	105	91	309	.....	.....	.....	.....	309
Totals	288	275	202	765	186	93	463	742	1507

DOCTORS TRY TO MEASURE INVISIBLE ORGANISM

An attempt to measure the world's tiniest living organism has been made by two St. Louis scientists, Drs. D. M. Hetler and Jacques Bronfenbrenner of the Washington University School of Medicine.

This organism is the bacteriophage, potent destroyer of bacteria. It is so small that it cannot be seen even with the aid of the most powerful microscope known to modern science. The radius of the average size particle of the phage is approximately one four-millionth of an inch, the two scientists calculated. Even this infinitesimal particle may not be the smallest unit of the phage but may serve as a carrier for still smaller ones.

The germ of typhoid fever, which can be seen under the microscope, is about six times as large. Some scientists do not think the bacteriophage is a living organism, but whether animate or inanimate, it is so small as to be almost beyond the conception of man.—Science Service.

THE TREATMENT OF CARCINOMA OF THE BREAST*

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Within recent years we have learned that carcinoma of the breast is not the simple disease that we had previously supposed it to be. Probably because of its superficial location we have taken the attitude that its treatment is comparatively easy. A more careful analysis of groups of cases, however, indicates that carcinoma of the breast like carcinoma in other locations must be considered as a serious and complicated disease and that in any case the choice of therapeutic procedure must be strictly individualized while our armamentarium must include every available method of proved value.

The results which may be obtained in the treatment of cancer of the breast as of malignant conditions in other locations depend upon the following factors:—(1) The age of the patient; (2) the duration of the disease; (3) the extent of involvement; and (4) the type of the neoplasm.

It is generally known that young women succumb to cancer of the breast sooner than elderly women especially if the neoplasm develops in a lactating breast. The second two factors, namely, the duration of the disease and the extent of involvement are usually intimately related and suggest the question, "When is a cancer of the breast operable?" There are widely different opinions as to this point as is shown by the fact that reports in the literature of the results of radical operation show from 15 to 50 per cent of five year survivals. Such a wide variation as this indicates that the important factor is the selection of cases to be operated upon, a factor which of course depends upon the judgment and experience of the individual surgeon. Unfortunately we have no generally accepted grouping for cancer of the breast, such for example, as that adopted for carcinoma of the cervix though several classifications have been suggested.

Classification according to cell type and tissue reaction would apparently be satisfactory in some instances but there is considerable disagreement among the pathologists who, in fact, seldom can agree upon the exact status even of a particular specimen.

Since the diagnosis of cancer of the breast is not difficult, little need be said about it. When a physician is consulted by a patient with a tumor in the mammary gland, he should assume that the condition is malignant until it is proven otherwise. "Watchful waiting for the classical text-book picture of cancer of the breast is an admission not only that the physician does not understand good practice and has no diagnostic acumen but it is unjustifiable procrastination. In case of doubt the patient should either be referred to someone of greater experience or a biopsy should be made at once. It is certainly better practice to remove a piece of tissue and wait for a pathologist's diagnosis than to allow a tumor to grow in the breast for several weeks or months.

When a tumor of the breast has been found to be malignant what advice should be given to the patient? Undoubtedly, except in advanced cases, the radical operation should be performed immediately. The radical operation as advocated by Halsted in 1897 should be a routine procedure since it has been proven by statistical studies that prior to the general adoption of this method only 26.5 per cent of patients with carcinoma of the breast survived for a three year period while since this method has been generally employed the average number of three year survivals has been about 38 per cent.

It would appear that the majority of surgeons do not realize that carcinoma of the breast is not a local disease and therefore an incomplete operation is sometimes performed. Of course in its incipiency carcinoma of the breast is a localized process, but in over 95 per cent of the total number of cases which come to the physician it has already metastasized to other areas in the mammary gland itself and to the axilla. The fact that cancer of the breast often extends into the breast area far beyond the original localized tumor has been well demonstrated by Dr. Wainwright, who has made serial cross-sections of the entire breast area. His study shows that a malignant growth is rarely a single nodule but

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that the whole mammary area is usually infiltrated with multiple tiny malignant areas many of which seem to be entirely independent of the primary tumor or of each other. It would appear that extension of the primary growth takes place not only through the larger lymphatic channels but also along the tissue planes.

Another reason for not assuming that a malignant tumor of the breast is a localized process is the fact that statistical studies prove that in less than 5 per cent of all cases is there no microscopic axillary involvement. If there are axillary metastases in such a large percentage of cases there must be a fairly large number in which there is also supraclavicular involvement though the exact percentage cannot be determined since surgeons seldom operate in this area. Moreover, Handley has shown that not infrequently the parasternal lymph nodes are involved fairly early in the disease and he has adopted a technic for radium implants in these areas.

It is, therefore, unsafe for a surgeon to look upon a malignant tumor of the breast as a local process; he should rather consider it as a generalized disease of the chest wall and shoulder girdle and should plan his therapeutic procedures accordingly.

If he bears in mind the fact that carcinoma of the breast is a wide-spread disease no surgeon will assume that he can in every case eradicate all malignant cells from the breast area and from the axilla by any operative method. It is probable indeed that some malignant cells remain after almost every operation for cancer of the breast. In many instances these cells are subsequently destroyed as the result of their lessened blood supply or because of resisting influences of the host or they may lie dormant for long periods of time. That malignant cells do lie inactive for long periods is proved by the very late recurrences and metastases, which frequently occur.

Although surgeons have been obtaining more satisfactory results since the radical operation came into general use they also realize that with this procedure they have reached the limit of the amount of tissue which can be removed. Certain technical maneuvers such as the use of the various types of cautery are sometimes advocated in the hope that thereby blood and lymph vessels may be sealed and malignant cells hemmed in, but with these methods no more involved tissue can be removed than with the scalpel.

In studying the effects of treatment of any disease, and especially of malignant disease, it is necessary to know something about the natural history of the process and what may be expected when a patient receives no treatment whatever. This can be accomplished only by studying large groups of cases from various sources.

In the case of cancer of the breast statistics show that the average period of life in untreated cases is three years. The value of different methods of treatment should be studied with this three year duration period in mind.

From the examination of many reports in the literature which cover thousands of cases I have found that after operation alone 38.6 per cent of the cases survive for three years and 28.8 per cent for five years. These figures indicate that only slightly more than one-third of the cases of cancer of the breast on which it is possible to operate will remain free of their disease for the period of natural life expectancy.

We know that in a large percentage of cases of carcinoma of the breast the disease is actually rather advanced before the condition is discovered and that it is impossible in most instances to remove all of the neoplastic cells, as is shown by the fact that but few more than thirty-three and one-third per cent of the cases survive the natural life expectancy. It therefore becomes necessary to avail ourselves of some adjunct to surgery as a means of assisting in the destruction of some of this remaining malignant tissue in order that the lives of even a few of our patients may be prolonged. Other than operation, the only procedure which is of recognized value is radiation therapy, the development of which is too recent for it to have become standardized or generally applied. There are some who doubt the benefits of radiation as a routine procedure but a careful analysis of cases must convince one that it certainly assists in reducing the number of recurrences and metastases, and definitely prolongs the lives of a certain number of patients. Those who are skeptical of the benefits of radiation usually base their conclusions on a few cases while others expect that radiation will definitely cure hopeless cases in the treatment of which they themselves have been unsuccessful. Neither these skeptics nor these optimists understand either the usual natural course of the disease or the effects of radiation. The effects of radiation are primarily due to the fact that certain neoplastic cells are more sensitive to the rays,

especially during mitosis than are normal tissues. Adult neoplastic cells and those approaching differentiation are not susceptible. Therefore, we cannot expect that all malignant cells will be completely or permanently influenced by radiation but there is no clinical method whereby to predetermine which cells are sensitive and which are not.

If radiation as an adjunct to surgery is found to improve the results obtained by surgery alone, even in the slightest degree, then no patient should be deprived of its possible benefits. Every surgeon has seen some hopelessly advanced cases of carcinoma of the breast receive definite benefit from radiation. It is only logical to assume that some cases in which the growth is less advanced must receive some benefit. Moreover, the fact must not be overlooked that although some cases may not be definitely cured by radiation we may, nevertheless, in some cases bring about an economic cure as the result of which the patient is able to carry on in comfort and happiness for a long period of time.

Some years ago, after the application of deep X-ray therapy in a series of 74 cases in which this treatment was given post-operatively by the cross-fire method advocated at that time, I observed more early recurrences and metastases than I had previously seen either among cases treated by moderate repeated dosage or among cases treated by surgery alone. A review of our cases which received this intensive radiation showed first year recurrences or metastases in 35.1 per cent of the cases as compared with only 16.5 per cent among the non-radiated cases.

This observation led me to make a comparative study of the results obtained by others using the same method and I found from a number of sources that the average number of first year recurrences and metastases amounted to 44.8 per cent among cases treated by intensive post-operative radiation as compared with only 25 per cent among non-radiated cases.

Since the number of early recurrences and metastases was apparently increased among cases treated by intensive radiation it would appear either that the malignant growth was stimulated or that the resisting influences were destroyed.

It has never been demonstrated that radiation actually stimulates an existing malignant growth but on the contrary it is well known that it either has no effect or produces some degree of destruction. It is also obvious that among these cases in which the recurrences and metastases were apparently increased malignant cells must have remained after operation, since the radiation could not induce a neoplasm to develop where none existed previously. It is also apparent that in some cases after operation these residual cells are destroyed subsequently by some resisting influence or may remain inactive for long periods of time, as otherwise the number of recurrences and metastases would be as great in the non-radiated as in the intensively radiated groups. We may be certain therefore not only that radiation has a direct destructive effect upon some malignant cells but that it also may either assist or destroy certain unknown factors which help to eliminate those cells. Because of the evident increase in the number of recurrences and metastases in the cases treated by intensive cross-fire post-operative radiation one must accept it as an indication that this method of treatment is an improper procedure. The application of this technic to such a superficial lesion as a breast would seem to be illogical since the large blood volume in the chest receives such an intensity of radiation that it not only destroys the cellular elements of the blood but also other factors which may help to make up the resisting influences of the patient.

This discussion of the unfavorable consequences of intensive cross-fire post-operative radiation in the treatment of cancer of the breast is not an admission that routine post-operative radiation is not beneficial but is rather a criticism of what I believe to be an improper method of application. It may also emphasize that the choice of technic for radiation is as important as the choice of surgical procedure.

In contrast to the number of first year recurrences which follow intensive radiation is the number of ultimate cases of five year survivals. In the series of cases previously cited the three year survivals amounted to 35.3 per cent for the non-radiated cases and to 47.1 per cent for those which received completed courses of radiation in moderate dosages. Studies of large groups of cases would seem to show that though there may seem to be more early recurrences or metastases among cases which are treated by radiation, nevertheless the number of survivals is greater than among the non-radiated cases. This may be accounted for by the fact that surgeons are prone to refer for radiation only

those less favorable cases in which they are sure that they have not been able to remove all the malignant tissue.

Since studying this problem I have discontinued the use of intensive post-operative radiation by the cross-fire method and have employed repeated moderate doses in an average of three courses. From January, 1924, to January, 1928, we ran two parallel series of cases in one of which the patients received post-operative radiation while in the other no radiation was given. All of these cases were clinically operable and all had axillary metastases. Of the cases which were radiated ten per cent more are free from recurrences or metastases than in the non-radiated group.

In about 15 per cent of patients who come to the surgeon with cancer of the breast the disease is so far advanced that it is impossible to operate upon them with any expectation of beneficial results. Usually these patients have ulcerating tumors and they always have axillary metastases and frequently palpable supraclavicular nodes or distant metastases. There is also a somewhat similar group of cases in which recurrences have developed very rapidly after operation. Radiation is the only possible means for the relief of such patients.

The term radiation applies not only to radiation with the X-ray but also to the use of radium. After the implantation of radium in needles or gold capillaries into and about the tumor, the application of radium packs to palpable distant areas of metastases and the use of judicious courses of X-ray therapy we are often gratified to observe the relief of the patient and often the complete disappearance of the lesions. Of course the successful treatment of these cases depends upon the sensitiveness of the malignant cells to radiation and I believe this is present in over 25 per cent of the cases. At present I have five such patients who have remained well for more than five years without receiving any other form of treatment. This is a small number, it is true, but it at least indicates the possibility that more cases may secure relief by this treatment.

SUMMARY

Having studied the problems presented by the treatment of carcinoma of the breast on the basis of reviews of the experiences of different operators in large groups of cases, we may conclude:—(1) that the average period of the natural duration of life for a patient with carcinoma of the breast is three years; (2) that as a result of radical operation about 38 per cent of the cases will be free from the disease for the natural duration of life and that the average survivals for five years will amount to about 30 per cent; (3) that intensive cross-fire post-operative radiation is harmful but that as the result of radiation by an appropriate technic we may expect at least ten per cent more patients to survive for five years than among non-radiated cases: (4) that we may expect gratifying results from radiation in some hopelessly advanced cases of carcinoma of the breast.

NEW PERSONALITIES FOR OLD, GOAL OF PSYCHIATRISTS

The chief reason for the existence of psychiatrists lies in their hope of changing unsatisfactory personalities, Dr. Karl A. Menninger of Topeka, Kansas, told members of the American Orthopsychiatric Association at a recent meeting. "If psychiatrists did not think the leopard could change his spots, they would not be in psychiatry," he said. Originally blame for all the evils of mankind was placed on the devil, Dr. Menninger told his audience. Later it was transferred to witches, "original sin", plain "orneryness" and finally to the "solemn theory of responsibility or irresponsibility." In the courts many thousands of dollars are spent annually to determine whether people have responsibility or do not have it. "If they have it they are locked up. If they do not have it they are locked up also," said Dr. Menninger. Orthopsychiatry, the new psychiatry, recognizes no devils but shifts away from these old ideas and principles to give its attention to the whole individual, mind and body. However, before orthopsychitary can treat personalities that are prone to failure, they must be classified. Dr. Menninger presented his classification which includes seven groups of such personalities. In the first are people predisposed to failure because of organic disease. They are found by physicians. In the second group are the stupid people, the hypophrenics, who are known to the psychologists. In the third group belongs the isolation personality. These individuals have been denied contact with the outside world because of physical deformity, financial difference or geographical location on lonely farms or outposts of civilization. They are unsocial, not asocial. They are usually discovered by the public. The fourth group, the asocial individuals or schizoids, and the fifth group of moody persons, cycloids, who fail because of incapacity to maintain an even tenor of emotional balance, are found by the psychiatrists. The sixth group contains the neurotics who are unhappy and at a disadvantage because of misdirection in early life. The neurologists and psychoanalysts discover this group. In the seventh classification belongs that ever recurring group of psychopathic personalities. These result more from the environment than from qualities in the individual. Dr. Menninger preferred to call these "orthopathic personalities" or "perverse personalities."—Science Service.

MICHIGAN'S DEPARTMENT OF HEALTH

GUY L. KIEFER, M. D., Commissioner
LANSING, MICHIGAN

COUNTY HEALTH DEPARTMENTS FOR MICHIGAN

The township system of government has been tried and found wanting in dealing with various modern conditions. It has practically been abandoned in dealing with law enforcement and the detection and prevention of crime, the development of adequate facilities for education, the improvement and maintenance of highways, the reclamation of land, etc.

In spite of the fact that the health of its people is of far greater importance than any material developments, this state until 1927 left the responsibility for health work to a very large extent with the township and incorporated municipality. That progress in such work has taken place under these circumstances speaks more for the efforts of individuals than it does for the antiquated system which has handicapped them.

To be enduring, organized health work should be a part of local government. To be effective, it should have jurisdiction over the largest feasible area, and its personnel should not only devote their whole time to their duties, but should be especially trained for their tasks. The largest unit of local self-government in this country is the country, and health work should be organized on the county as a base. Even a county-wide organization is inadequate in handling certain problems which arise.

The development of improved highways, and the ubiquitous automobile have brought about a condition which is of the greatest importance to public health. Thus, populations of enormous size are constantly on the move. Hundreds of thousands of people cross the borders of this state on errands of business or pleasure. In some of the remote counties of Michigan this transient population is from five to ten times that of the permanent population. Furthermore, the permanent population is constantly traveling. Thus no township or municipality is concerned alone with its own people, counties and even states are vitally concerned with the health of people far removed from their jurisdictions. Michigan has obligations with reference to safeguarding the health both of its residents and of its visitors. The only solution for the problem arising in this connection is adequate health organization. It is imperative that such organization be effected at as early a date as possible.

The last legislature made provisions which will materially aid in the development of whole-time county departments. From this source and from funds granted by the Rockefeller Foundation, subsidies are available which will enable counties to organize health departments.

The physicians of Michigan will be deeply interested in the program for county health departments as it is being developed by Dr. Guy L. Kiefer, State Commissioner of Health. Dr. Kiefer bases his program upon the principle that the functions of a health department lie exclusively in the field of preventive medicine and in the field of health education. All curative measures are primarily individual in character, and therefore are properly the field of those engaged in the practice of medicine. Health departments may be of great indirect assistance to physicians in this field, but actual curative measures lie beyond their proper sphere.

County health work built upon this fundamentally sound basis cannot but prove of the greatest value to a community and to the physicians of the community. Inasmuch as in certain phases, the work of practicing physicians is closely related to the activities of the health department, it is expected that the county medical society will serve in an unofficial advisory capacity to the county department of health.

The program is now being presented to the various counties of Michigan. The first presentation is being made to the county medical societies. If and when the societies officially endorse the plan, it is then presented to the supervisors and to various organizations interested in community betterment. The county supervisors constitute the only legal authority back of the county health departments, and the adoption and maintenance of the plan rest solely with them.

The State Department of Health is ready to aid in this program in several important ways. From the funds available, it is ready to grant a very liberal subsidy to such counties as may adopt this plan. The minimum staff recommended consists of one whole-time health officer, two whole-time public health nurses, and one office assistant. The minimum budget required is $12,000 annually, of which the State Department of Health subsidies will provide

$5,500. This leaves a balance of $6,500 to be provided by the supervisors.

It is of fundamental importance that the personnel of these county health departments be especially trained for their duties. The State Department of Health is providing facilities for giving the preliminary training required.

It is of importance also that there be developed some degree of uniformity of programs among these county health departments, and that they be so linked up that in times of necessity prompt and simultaneous action may be taken throughout the state. The State Department of Health is therefore providing for a system of co-ordinating these activities.

The program is one that it is believed every physician in the state can heartily endorse. Most of the societies to which it has thus far been presented have taken official action, and the members of these various societies are urging upon their supervisors its adoption. The success which has attended the work of county departments of health in other states has removed any element of experimentation that might be attached to a new development. The program is rightly considered by those who have studied is possibilities carefully to be one of the most progressive measures as yet undertaken by the State Health Department in Michigan.

M. E. B.

DIPHTHERIA PROTECTION IN MACOMB COUNTY

Organization work for an intensive diphtheria protection porgram is being carried on in Macomb County by local health and school authorities assisted by a representative of the Michigan Department of Health. Administration of the toxin-antitoxin will be done by local physicians. Macomb County is one of the eight counties in the state having the highest diphtheria death rates, so that especial interest attaches to the effort to improve the county's record.

The campaign is being planned by townships, with intensive educational work reaching all organized groups. It is hoped that a large percentage of preschool children may be immunized.

INSPECTING SUMMER RESORTS

Sewage disposal and milk supplies are the two items in summer resort sanitation in Michigan that need the most attention, according to a preliminary analysis of the records of 200 of the 1,531 resort inspections made by representatives of the Bureau of Engineering during the past summer. Bathing beaches were found generally satisfactory.

Seven items were checked upon by the six inspectors assigned to the six districts into which the state was divided for this work. These items were water supplies, sewage disposal, garbage and rubbish disposal, the milk supply, the camp site, food handling, and the bathing beach. An arbitrary system of grading was adopted giving to water supplies 20 points, to sewage disposal 20 points, and to milk supplies 20 points. All the other items received 10 points each, and the whole score was 100 points.

Seventy-one counties located in both upper and lower peninsulas were included in the summer resort inspection program. A total of 1,531 resorts were visited. The 70 inspections that were made in the Upper Peninsula necessitated 4,000 miles of travel.

A more complete report of all findings will be made later.

COURSE IN APPLIED HYGIENE FOR COUNTY NORMALS

The series of lectures on applied hygiene that was given by Department representatives to 35 of the county normal training classes last year, in co-operation with the Department of Public Instruction, will be repeated this year. All 50 of the county normals of the state will be included in the offer.

Five lectures give the talks and demonstrations. Topics to be discussed in this year's series include personal and community health, health inspection of children, control of classroom contagion, mouth hygiene, and methods and materials for teaching health.

Seven hundred and fifty students were enrolled in the county normals visited by the Department lectures last year, and a large percentage of these students are now teaching in rural schools.

THE NEW PLUMBING INSPECTION LAW

The new law "to provide for the licensing of plumbers, the supervision and inspection of plumbing and the adoption and enforcement of minimum standards therefor by the state commissioner of health, with the concurrence of the advisory council of health" went into effect August 28. It is estimated that between 4,000 and 5,000 master and journeymen plumbers in the state will be brought under the provisions of the law.

Licenses will be required of all plumbers

after January 1, 1930. Up to that time, they will be issued without examination to all persons who furnish proof that they were engaged in the business of master or journeyman plumber on March 1, 1929, and possess the necessary qualifications. After January 1, 1930, examination will be required before a license is issued. Registration of plumbers' apprentices is also provided for by the law. A system of fees for examination and for renewal of licenses is prescribed.

Enforcement of the law is to be handled by the Bureau of Engineering. Plumbing inspection will be started after the first of the year, when the license system is in operation.

THE ROADSIDE WATER SURVEY

A preliminary report of the work carried on by the Bureau of Engineers during the past summer for the protection of motorists using roadside drinking water supplies has just been issued.

In all, 1,907 sources of water supplies were investigated and 1,941 samples were tested.

A departure this year was the addition of approximately 1,000 miles of county roads. As in the past, the majority of the main trunk lines were covered.

The percentage of supplies found safe during the past summer was 83.2, about the same as for the last year.

CHILD HYGIENE FIELD NOTES

The series of Women's Classes in child carethat have been conducted in Lake and Osceola Counties by Dr. Ira Alexander have just been completed. A series of Muskegon County will be begun by Dr. Alexander October 7.

Dr. Florence H. Knowlton, also of the Bureau of Child Hygiene and Public Health Nursing, started Women's Classes in Cheboygan County on September 23.

Child Care Classes, teaching the principles of child care to girls from 10 to 15 years of age, are now being conducted in Arenac County by Miss Bertha Cooper, in Delta County by Miss Annette Fox, and in Ontonagon County by Miss Julia Clock. All three nurses are from the staff of the Bureau of Child Hygiene and Public Health Nursing.

PREVALENCE OF DISEASE

September Report

Cases Reported

	August 1929	September 1929	September 1928	Av. 5 yrs.
Pneumonia	176	203	241	198
Tuberculosis	807	456	233	417
Typhoid Fever	43	49	61	109
Diphtheria	227	254	239	279
Whooping Cough	783	518	874	641
Scarlet Fever	307	330	322	366
Measles	228	235	75	85
Smallpox	113	73	36	32
Meningitis	66	84	17	10
Poliomyelitis	27	52	25	89
Syphilis	1,730	1,300	1,512	1,401
Gonorrhea	1,217	888	921	1,014
Chancroid	52	37	9	11

INCREASED TARIFF ON SURGICAL INSTRUMENTS

On behalf of certain surgical instrument makers, Mr. Charles J. Pilling of Philadelphia recently urged before the Committee on Ways and Means of the House of Representatives that the duty on such instruments be increased. The law now imposes a duty of 45 per cent ad valorem. Mr. Pilling proposed that this duty be raised to 75 per cent ad velorem, plus certain specific duties, and that hypodermic and dental needles be included in the schedule as surgical instruments. The added specific duties would vary from 1 cent each on articles valued at not more than 25 cents a dozen to 60 cents each on articles valued at more than $24 a dozen. In justification of this increase, Mr. Pilling represented that at least 90 per cent of the surgical instruments used in this country are imported, and he implied that the increased duty would build up an industry that could supply all surgical instruments needed by the United States, in war as well as in peace. Hospital expenditures for surgical instruments, it was stated, averaged only about one fourth of 1 per cent of their total annual expenditures, and the surgical instrument makers represented at the hearing seemed to think that the increased duty would not add materially to the burdens of such institutions. Purchases by individual physicians were represented as a minor factor in the surgical instrument trade. The Board of Trustees of the American Medical Association was unable, however, to find evidence that an increased duty such as was proposed could be made without adding substantially to the expenses of hospitals and of the practice of medicine and surgery. Evidence was not found to show that the increased expense to which hospitals and the medical profession would be subjected could reasonably be depended on to expand the surgical instrument industry in the manner suggested. The Board of Trustees therefore filed a protest with the Committee on Ways and Means against the proposed increase in the duty on surgical instruments. Physicians interested in this matter as individuals or as organizations, and the responsible officers of hospitals, if they desire to avoid the payment of such increased prices for surgical instruments as may reasonably be expected from the proposed increase in the duty on such instruments, will do well to file protests with the Committee on Ways and Means of the House of Representatives and with their respective Representatives. — Jour. A.M.A.

TRUTH ABOUT MEDICINE

PROPAGANDA FOR REFORM

Ergot Preparations Omitted From N.N.R.: An Explanation.—In the Journal of the American Medical Association, May 4, 1929, there was published a report by the Council on Pharmacy and Chemistry on certain preparations of ergot which were intended for hypodermic administration. This report stated that the preparations had been omitted from New and Non-official Remedies because they were essentially watery extracts of ergot and therefore contained little or none of the specific alkaloids of the drug; because, with one exception they were not assayed by any method which showed their alkaloid content; and that an examination had shown that they were practically devoid of the specific alkaloids. Inasmuch as there seems to be in certain quarters some misunderstanding of the action, the Council on Pharmacy and Chemistry points out that the reasons for omitting these preparations are those stated in its report, and the Council emphasizes that no evidence was found to indicate that in any case there was adulteration, or that improper ergot had been used in the manufacture of these products. Nor was any preparation found to be unduly toxic. (Jour. A. M. A., September 7, 1929).

RADIOACTIVE WATERS AND SOLUTIONS

Not many years have passed since the Council on Pharmacy and Chemistry, basing its decision on the then available evidence, admitted to New and Non-official Remedies various preparations containing in solution radium or radium emanation (radon), and various devices for causing radium emanation to pass into drinking water. The evidence was not extremely well controlled or profuse in amount, but there seemed to be a demand by physicians for such preparations and the Council considered it worth while to set up at least minimum standards of radium content or radium activity. Actually, innumerable preparations were on the market which contained insufficient radium to have any demonstrable effects. Now the Council has issued the following statement: From an examination of the available evidence, it appears that the value of the internal use of radium solutions or of water containing radon in chronic arthritis, gout, neuritis and high blood pressure is not demonstrated by controlled clinical evidence; that in spite of many years of trial, acceptable evidence has not become available and until such evidence does become available the Council has decided not to accept generators for the production of water charged with radon or radium solutions intended for intravenous use. The announcement by the Council disposes of the claims made for all sorts of solutions and for the devices to be used in preparation of such solutions, whether they contain considerable amounts of radium or but insignificant traces. (Jour. A. M. A., September 7, 1929).

* The Journal of the Michigan State Medical Society under this heading, "Truth About Medicine," will contain matter furnished by the American Medical Association which will be of practical interest to our readers. It will deal principally with new and official and non-official medicinal agents.

THE NICOTINE CONTENT OF TOBACCO

About a year ago, the Connecticut Agricultural Experiment Station published a report which showed that the claim that certain tobaccos had been "denicotinized" was largely without foundation, for it was found that there were, among ordinary tobaccos, brands in which the nicotine was either not in excess or was actually lower than that present in the processed tobaccos, sold under the implied claim that they were practically free from nicotine. The station has now issued a further report giving the results of the analysis of tobaccos of both the processed and unprocessed types. Altogether, eleven brands of unprocessed pipe tobacco have been analyzed and found to have an average total nicotine content of 2.04 per cent; four brands of so-called denicotinized pipe tobacco gave an average total nicotine content of 1.3 per cent; ten brands of ordinary unprocessed cigars gave an average total nicotine content of 1.51 per cent, while several brands of processed, or so-called denicotinized, cigars gave an average total nicotine content of 0.95 per cent. In the cigaret field forty-six analyses were made of ordinary unprocessed products, giving an average total nicotine content of 1.77 per cent, as compared with 1.09 as the total nicotine content of twelve so-called denicotinized brands. From this work it can be seen that while some of the so-called denicotinized products contain less nicotine than the ordinary unprocessed brands of the same class, they still contain material quantities of nicotine. The main difficulty in determining whether or not the claims made by manufacturers of so-called denicotinized tobacco products are reasonable lies in the failure to know the amount of nicotine in the various tobaccos before they were processed. However, this work permits the tobacco user to arrive at some worth-while conclusions on this point. It should not be forgotten, also, that nicotine is probably not the only harmful element in tobacco smoke, and that Dixon has reached the conclusion that moist tobacco produces much more serious effects than dry tobacco, and has even suggested that the water content of tobacco might be a more harmful factor to the smoker than the nicotine content of the tobacco, and that the condition of the tobacco and the form in which it is smoked are probably more important factors in determining the amount of nicotine that the smoker gets than is the actual nicotine present in the original tobacco. (Jour. A.M.A., September 21, 1929).

THE U. S. PHARMACOPEIAL CONVENTION

The Council on Pharmacy and Chemistry has issued a report calling attention to the call for the appointment of delegates to the United States Pharmacopeial Convention. The Council urges all the organizations which are entitled to delegates to select persons who are noted for high ideals, for breadth of vision, for sane understanding, and for sound judgment, as well as for technical knowledge, men who are fitted by temperament and training to collaborate, to help by deed and by counsel to keep the United States Pharmocopeia a work in which American medicine and American pharmacy may feel a just pride; a work that fairly reflects modern medical and pharmaceutic science; a work that is conservative of the best of the past, and progressive; constructive, sensitive to the best of the new. The Council discusses the character of the work of revision and the men required for this work. It points out that the selection of drugs to be admitted to

the Pharmacopeia must be determined primarily by their therapeutic usefulness; that these are medical matters, and therefore fall within the technical province of the physicians of the revision committee; and that the definite recognition of this principle in the last revision contributed notably to its success and should be continued. The Pharmacopeia should be a working manual of the present era and not an antiquarian museum. New drugs should be admitted freely when their therapeutic usefulness appears established, and some old drugs which have fallen into neglect or disrepute should be omitted. The policies of the present revision have earned for the Pharmacopeia "the sanction of the medical community and of the public" and may safely be continued. (Jour. A.M.A., September 28, 1929).

THE UNITED STATES PHARMACOPEIA

The United States Pharmacopeia is published by authority of the United States Pharmacopeial Convention. This body meets once every ten years, and its chief function is the selection of the Committee of Revision of the United States Pharmacopeia. To this committee is assigned the task of issuing the revised edition of the book. The next Pharmacopeial Convention has been called for May 13, 1930, at which time the delegates appointed by the constituent bodies will meet and inaugurate the preparation of the eleventh revision of the Pharmacopeia. At the time when instruction in medical schools in subjects related to therapy and drugs was woefully deficient, and when conditions made necessary the establishment by the American Medical Association of its Council on Pharmacy and Chemistry, the Pharmacopeia promised to degenerate into a mere book of standards for drug control officers. In 1916, when the ninth revision of the Pharmacopeia made its appearance, it was pointed out that it was a book of standards for drugs but not a book of standard remedies. Largely as a result of the renewed interest in scientific drug therapy which was created by the Council on Pharmacy and Chemistry, there was so much interest taken in the following revision of the Pharmacopeia that, at the convention held in 1920, the medical members of the revision committee were in effect delegated to decide which of the drugs in the ninth revision were to be retained in the tenth and which were to be omitted as being of insufficient usefulness, and as a result the tenth revision is a book with which physicians and pharmacists may justly be satisfied. In order that the next revision may correctly reflect the advances in drug therapy, the medical and other bodies entitled to send delegates to the coming convention should give serious consideration to the appeal of the Council on Pharmacy and Chemistry that competent delegates be sent to this convention. (Jour. A.M.A., September 28, 1929, p. 990).

MORE MISBRANDED NOSTRUMS

The following products have been the subject of prosecution by the Food, Drug and Insecticide Administration of the United States Department of Agriculture which enforces the Federal Food and Drug Act: Odol (The Odol Corporation) consisting essentially of alcohol, 78 per cent, salol and water, flavored with volatile oils, including peppermint. Sorbefacin (The Foster-Dack Company) consisting essentially of zinc oxide with traces of menthol and thymol in a petrolatum and fatty acid base. Clear-Tone (The J. T. Kennedy Company) containing 42 per cent of alcohol, with calomel and alum and small amounts of potassium nitrate, camphor and tannin, together with water. Giles Magic Lotion and Blood Purifier (The Giles Remedy Company) consisting essentially of camphor and ether in linseed oil. Creomulsion (Creomulsion Company) consisting essentially of creosote, menthol, a small amount of alkaloidal material, sugar, gum, water and a small percentage of alcohol. Lax-Krax (The Cubbison Cracker Company) a bran cracker containing senna. Lee's Creo-Lyptus (Creo-Lyptus Company, Inc.) consisting essentially of ammonium chloride, chloroform, plant extractives, traces of volatile oils (with a possible trace of creosote) sugar, alcohol and water. Bacid Tablets (The Arlington Chemical Company) claimed to contain bacillus acidophlius the strength of which fell below the professed standard. (Jour. A.M.A., September 28, 1929).

Mum—Nonspi—Odorono—In 1914, Mum was found to contain essentially zinc oxide and benzoic acid in a fatty base. In 1915, it was reported to contain salicylic acid, zinc oxide, glycerin, water, a tallow-like fat and traces of essential oils. Later the A.M.A. Chemical Laboratory found the product to contain 3 per cent benzoic acid and not salicylic acid. According to information available, the base of Nonspi is aluminum chloride dissolved in water containing some potassium and iron. In 1915, Odorono was found by the A.M.A. Chemical Laboratory to contain a 33 per cent solution of hydrous aluminum chloride. (Jour. A.M.A., September 28, 1929).

DESCRIBES NEW TEST FOR SCARLET FEVER CARRIERS

A simple new test for detecting carriers of scarlet fever was described by Dr. Ruth Tunnicliff of Chicago before the Laboratory Section of the American Public Health Association at Minneapolis. The test was devised to identify the organism of scarlet fever, and is well adapted for use in detecting carriers. By this test the organism can be identified in from 24 to 48 hours after the culture is made.

Results of a study of Drs. William D. Frost and Myrtle Shaw with R. C. Thomas and Mildred Gumm, from the University of Wisconsin, of the organism that causes septic sore throat were also presented to the Laboratory section. Severe epidemics of the disease have been caused by infected milk. The organism may get into milk by outside contamination or it may come directly from infected cows that have a condition known as mastitis. In the latter case, these scientists found that the cows do not always show any symptoms of mastitis. This may be an important factor in the start of the disease even in communities where there is milk inspection. For four years the scentists have been making routine examinations of milk from all cows and of throats of all employees on farms supplying the Chicago district with certified milk.

"We have studied 17 cows, 8 from the certified herds and 9 from other herds, that were shedding streptococcus epidemicus in their milk. About half of them showed no signs of clinical mastitis, and there was such a slight abnormality in the cows and their milk, that it was quite evident they would not have been excluded from the herd for a considerable time by a clinical examination."—Science Service.

Official Minutes of the 109th Annual Meeting of the Michigan State Medical Society held in Jackson, Michigan, September 17, 18 and 19, 1929

GENERAL SESSION

Wednesday Evening, September 18, 1929

The General Session, held in the First M. E. Church, Jackson, Michigan, convened at seven forty-five o'clock, President L. J. Hirschman, Detroit, presiding.

President Hirschman: It is my pleasure to call to order the One Hundred and Ninth meeting of the Michigan State Medical Society, and I will ask Dr. Spence for the invocation.

Rev. Frederick Spence: Let us pray:

Almighty God, our Father, we thank Thee for the revelation of Thyself in nature through history and in the movements of our modern day. We thank Thee that miracles are not past; they are still being performed, and we thank Thee for those things which we did not understand, and before which we bowed to mystery, are becoming the things which have been unfolded to us by the aid of modern science.

We thank Thee as we come to understand the laws through which Thou has operated in the past. Thou art not becoming thrust out and hewed out by Thy universe but that increasingly Thou art becoming a part of the whole of life.

We thank Thee for the new conception of the meaning of religion, that it is not concerned with the pearly gates and the golden streets of the land beyond the Valley of the Shadow called Death but increasingly we are coming to realize that it is the rule of Thy law in the whole of life and that slowly, but surely, we are finding Thee, not in the shining of the stars merely but in the higher ideals and impulses of the human heart, in the walks of our common life.

We thank Thee for the new meaning of the cross, that increasingly it is not an event of the past through which by mystical methods men defined their oneness with Thee but it is the incarnation of the spirit of the Nazarene into the whole of life by which men find their way to coronation, not through force but through the law of service.

O, God, we thank Thee that religion is not merely of the temple, it is of the laboratory, it is not merely a part of but it is in life. We thank Thee for the heroes of the common life in the field of science, in the art of medicine, the men who have followed Thee and climbed their own cross that through their surrender to knowledge and the new sciences they may render a great service to their fellowman.

We pray Thy blessing upon this gathering tonight and upon these men who are realizing, as we who seek to interpret the mind of the Carpenter of Nazareth, that after all He is the greatest, ministers the most, and the finest expression of our recognition of Thee is in the service that we render to our fellowmen.

Guide and direct all that shall be said and done tonight. These things we ask in Christ's name. Amen.

President Hirschman: Ladies and Gentlemen: It is my great privilege and pleasure to present, to those of you who do not live in Jackson or in this part of the state, a man who is so well known to a Jackson audience that an introduction would be superfluous. I would like to present Dr. Hungerford, President of the Jackson County Medical Society.

Dr. Hungerford! (Applause)

Dr. Hungerford: Members of the Michigan State Medical Society, Ladies and Gentlemen: It is indeed a great pleasure to welcome the Michigan State Medical Society back to Jackson.

We have waited for twenty-three years for your return. During that time Jackson has grown from a small city to one of sizeable proportions, whose voice is heard throughout the world.

During that same time our County Medical Society has developed from a mere infant to a full-grown adult so that at the present time we have a total membership of practically 100 per cent in the county.

We feel proud of Jackson and her institutions of which she has many. We feel proud of our hospitals, about which you have doubtless read in a recent number of the Medical Journal.

There is one hospital, however, of which the Journal mentioned nothing and in case any of you should desire to avail yourselves of its privileges at any time in the future, I might mention the fact that we have a splendid hospital connected with our Michigan State Prison. (Laughter)

Jackson feels highly honored to entertain such a splendid organization as yours.

Now, Mr. President and members of the Michigan State Medical Society, we bid you a hearty welcome. We hope that your brief stay will be filled with much pleasure and profit to every one concerned. (Applause)

President Hirschman: On behalf of the Michigan State Medical Society, Dr. Hungerford, I wish to thank you for the cordial welcome you have given us. I wish to say that I was deeply touched this after-

noon when I had occasion, while traversing the broad avenues of your beautiful city, to see a beautiful electric light over that wonderful state institution of reform and hope, the Michigan State Prison, and there were the words, "Welcome Members of the State Medical Society." (Laughter)

I wish to congratulate the prison physician and his associates that at last there is one place in the state of Michigan where a man's practice cannot be stolen from him.

President Hirschman: We will next hear from Dr. Stone the chairman of the Council of the State Society.

Dr. R. C. Stone: Mr. President and members of the Michigan State Medical Society, and Guests: It is with a great deal of pleasure that I have the opportunity of talking for a few minutes this evening, very briefly, of one of our members who, for a period of twenty-five, thirty or more years, has rendered this Society and the people of the state of Michigan the most valuable service. He is a man who has given unstintingly of his time. He has been untiring in his efforts. He is a man who has always been thoughtful of his fellow doctors, a man who has always had the courage of his convictions and the spirit to follow them through, a man who has been a bitter opponent of unfavorable legislation and has given most hearty support to favorable legislation, a man whose life work has been a beautiful portrayal of the most popular motto of today, "Service before Self."

In addition to serving the Society he has served the people of Michigan in many capacities. In that service he has shown the same untiring disposition and spirit. No matter when duty called him he has never considered himself, he has gone and served happily, willingly and faithfully.

His service has been of that type that we all hold him in the highest esteem and have the utmost regard and admiration for him. He is a very kindly gentleman, a faithful servant and a loyal friend, Dr. Guy L. Kiefer. (Applause)

Dr. Kiefer has been honored during the past twenty-five or thirty years with many positions of trust and he has always fulfilled those positions with credit to himself. For many years he was Health Officer of the city of Detroit and a member of the Board of Health of that city. For about that many years he has been a Professor of Public Health and Hygiene on the faculty of the Detroit College of Medicine.

Dr. Kiefer has served the Society as its President and in numerous other capacities. For the past few years he has served the state as Commissioner of Health. Dr. Kiefer is largely responsible for many of our present public health activities. Our State Board of Health is recognized throughout the country as one of the leading Boards of Health in the country and much of this is due to his efforts.

During the past two years as Chairman of the Commission on Legislation his duties have been very trying and his responsibilities have been many. Constantly during the past session Dr. Kiefer was actively on duty endeavoring to conserve our legislative interests. The story of the Legislature has been told but it was through no fault of Dr. Kiefer's that it wasn't better than it was.

The Society owes Dr. Kiefer many, many thanks. I doubt if we will ever be able to repay him for the time which he has spent in our behalf.

Dr. Kiefer, on behalf of the Michigan State Medical Society, it gives me great pleasure to present you with this very small token of the appreciation of our members. (Applause)

. . . Dr. Kiefer was presented with a traveling bag, the gift of the Society and was escorted to the rostrum. . . . (Applause)

Dr. Guy L. Kiefer: Mr. President, Chairman of the Council, Ladies and Gentlemen: The members of the State Medical Society here know that usually when I get on my feet I have something to say. However, on this occasion I am nearly struck dumb.

Before I forget it, Mr. President and Mr. Chairman of the Council, I want to say most heartily, "Thank You!" I wanted to get that off my chest.

It seems to me that this action on the part of your Council and on the part of the Society is rather the reverse of what usually happens. Usually if men are thanked and their services are appreciated it is because they have accomplished something, because they have delivered the goods.

The last time I tried to deliver some goods for the Society and the people of Michigan I failed. We didn't get the legislation that would have been for the good of everyone and in which the doctors were interested because of the benefit that the people would have derived from it. Just

why a person should be made a hero when he fails is pretty hard to say.

But, Mr. President, your action is very pleasing just the same, even though it is irregular. I do not believe I have ever heard so many nice things said about an individual during his life. If a fellow does something that is worth while it is usually talked about after he has gone. It seems I have succeeded in doing something and I have been told about it while I am still here. It is very pleasing indeed.

There is one other thought that comes to me, that is, if you are going to emphasize your good will and your good judgment by a gift you couldn't have done anything better than to have selected one of leather. You know that I have a mania for leather goods. Since you have selected something of leather I want to say that the selector of this particular gift is a good picker. He picked out something that is useful and very beautiful. The nicest thought that comes to me and the nicest feeling that I have about the presentation is that it comes from the medical profession.

I once heard Dr. Carstens say in a meeting of doctors, an alumni association meeting, when he was talking to the doctors about what they were going to do when they got out in different parts of the state and how they got along and whether they were to accomplish success, "I hear of some of these fellows but I am never satisfied with what they are until I find out what the doctors think of them."

I have always remembered that. I think that is the nicest part of what has been done for me and to me tonight.

I thank you! (Applause)

President Hirschman: Ladies and Gentlemen: Those of us who have known Dr. Kiefer even for a short time only—you don't have to know him for many years—realize the fact that he not only is an extremely efficient man but he is one of the world's most modest individuals. He had the temerity to get up before the Society tonight and thank you for presenting him with a token of appreciation because of a failure. If that isn't the quintessence of modesty then I don't know what is.

Those of us who have listened to Dr. Kiefer as he has talked and exhorted with us on the subject of preventive medicine realize that the greatest exponent of preventive medicine did one of the greatest pieces of preventive work by preventing vicious legislation from passing and still he says he is a failure.

Dr. Kiefer, in our early days of legislative struggle out there, was a source of inspiration to me. When I got out there and had to follow in his footsteps, chasing around legislators, he was not only a source of inspiration but a decided source of perspiration.

Gentlemen, we now come to one of the unfortunate parts of the program, which is the President's annual address.

I would like to call Dr. Warnshuis to the chair at this time. (Applause)

. . . Secretary Warnshuis assumed the chair. . . .

Chairman Warnshuis: Ladies and gentlemen: In the hundred and nine years of our organizational existence through some good fate, or happenstance, from year to year from our number some distinguished man of the medical profession in Michigan has been elected to the office of President. They have served us well. There has never been an impeachment of a President of the Michigan State Medical Society.

Through that same good fortune this last year, although in close proximity to our state penal institution, we have had a President who has served well. It is my pleasure to introduce him to you tonight, Dr. Louis J. Hirschman of Detroit. (Applause)

. . . The President delivered his annual address. . . . (Applause)

. . . President Hirschman resumed the chair. . . .

President Hirschman: Ladies and gentlemen: The next speaker on the program is a gentleman who has really no need for an introduction. He is well known in the state of Michigan by the wonderful record he has made in the educational world. It is not necessary to present him to this audience, but I wish to bring both audience and speaker together. At this time I want to relinquish the platform to the Dean of Administration of the University of Michigan, Dr. Alexander G. Ruthven, who will give you some comments on medical education. (Applause)

. . . Dr. Ruthven presented his prepared paper. . . . (Applause)

President Hirschman: This seems to be an evening of problems. In the President's remarks there were a few problems discussed, Dean Ruthven has brought some problems of medical education before you and the next address, the address of the evening, is entitled, "Some Inter-related

Problems of the Public and the Doctor."

By the time the evening is finished we are going to have a good deal about which to cogitate and about which to formulate.

We feel particularly happy and complimented to have this occasion graced by the presence of the President-elect of the American Medical Association because those who know him love him because of his personal charm as well as his erudition, they realize that on account of these and many other qualities he is a much sought for gentleman.

We feel particularly happy to think that of the many invitations which he has received, this is the first one he has accepted since his election to office.

We take pleasure in welcoming him to our midst and presenting him to you at this time. Dr. William Gerry Morgan, of Washington, the newly elected President of the American Medical Association.

. . . The audience arose and applauded. . . .

. . . Dr. Morgan presented his prepared address. . . .

President Hirschman: Ladies and gentlemen, and members of the Society: I think you will all agree with the presiding officer that our guests have rendered us a valuable service and have given us a wonderful treat.

On behalf of the members of the Michigan State Medical Society I wish to thank you for the contribution to the evening's program. (Applause)

Dr. C. R. Burr (Flint): Before passing to the next order of business I would like to lift up my voice. I would like to make two motions.

First: One to be presented by yourself, that the thanks of the assembly be extended, by a rising vote to Dr. Ruthven and Dr. Morgan for their admirable addresses.

. . . The motion was seconded variously and carried by a rising vote. . . . (Applause)

Dr. Burr: The second—this is for you.

. . . President Hirschman relinquished the chair to Secretary Warnshuis. . . .

Dr. Burr: Now I will give the second. A rising vote of thanks be given our retiring President, our cheerful, busy, useful, devoted retiring President for his excellent address and his interest so long continued in the Society.

. . . The motion was variously seconded and carried by a rising vote. . . . (Applause)

Chairman Warnshuis: Your audience has demonstrated their loyalty and appreciation to you.

. . . President Hirschman resumed the chair. . . .

President Hirschman: Now comes one of the pleasant duties of this position, and before announcing that particular subject, have we any announcements?

Secretary: No.

President Hirschman: Then nominations for President for the ensuing year are now in order.

Dr. C. G. Jennings (Wayne): Mr. President, the advance in medicine has brought many problems to the economical, social, educational aspects of this matter. We have heard, from our guests, this evening a discussion of these problems, or some of them. I noted that not one of our guests attempted to solve those problems.

There is another problem that has been looked upon as such in the medical profession, that is the problem of the general practitioner. What is he? What is his future? What is to become of him? He has a place in medicine hasn't he?

I am not following the example of my predecessors, I am not going to predict what is to happen to the general practitioner of the future, but we know at the present time that the general practitioner is the bulwark of the medical profession. We know very well that he constitutes from 70 to 75 per cent, or maybe 65 to 70 per cent would be more conservative, of the profession of the country. Therefore, he is an important individual.

The Michigan State Medical Society has always recognized the general practitioner as a very important individual in its ranks. It has elevated him to posts of honor and posts of responsibility. He has always filled those posts with honor and responsibility.

The State Medical Society has also recognized the representatives of all other departments of medicine, as a matter of fact in our past we have had representatives from all the field of medical endeavor. We have had, in the past few years, those who represent special departments in medicine. The time has come now to recognize, again, the part of the profession that represents the great bulk of the work that is done and the hard work that is done in our communities.

I have a candidate—or we have a candidate to speak properly, because he isn't

my candidate but is the candidate of a great many and I hope the majority of the members of the Michigan State Medical Society. To us it is unnecessary to eulogize him. We all know what he represents. We all know that in his community he is beloved by his patients and he has the respect and confidence of his colleagues.

He has gone out from his little community and he has become a national character, as much as it is possible for one whose field of activity in actual medicine must be rather limited. As a member of the House of Delegates of our State Society, as a member of the House of Delegates of the American Medical Association, he has represented our state and his community in the best possible way.

He has served for ten years as a member of the State Board of Registration and in this way guarded the best interests of the medical profession. I have great pleasure and really take great pleasure in nominating, for the Presidency of the Michigan State Medical Society, for the coming year, J. D. Brook of Kent County. (Applause)

Dr. Moll: On behalf of Genesee County I deem it a great honor to second the nomination of that sterling practitioner, that true and tried colleague, that untiring laborer of scientific and organized medicine, J. D. Brook of Kent County. (Applause)

Dr. W. J. Cassidy (Wayne): I move the nomination be closed.

President Hirschman: Are there any other nominations? If not, I will entertain the motion of Dr. Cassidy of Wayne that the nominations be closed.

Dr. Cassidy: And also the Secretary cast the unanimous ballot of the assembly for Dr. Brook as President.

. . . The motion was supported by several. . . .

President Hirschman: The nominations are closed and the Secretary is to be instructed to cast the unanimous ballot of the Society for Dr. J. D. Brook of Kent County for President for the ensuing year —that is the motion.

. . . The motion was carried. . . .

President Hirschman: The President is duly elected.

The next order of business is general business. Is there anything to come before the House at this time? If not, we will adjourn.

. . . The meeting adjourned at nine-fifty o'clock. . . .

PROCEEDINGS OF THE HOUSE OF DELEGATES

TUESDAY MORNING SESSION

SEPTEMBER 17, 1929

The first session of the House of Delegates was called to order in the ballroom of the Hotel Hayes, Jackson, Michigan, by the speaker, Henry J. Pyle, Grand Rapids, at 10:30 o'clock.

Speaker Pyle: We will now listen to the report of the Credentials Committee.

Dr. W. E. Chapman (Cheboygan): The total number of delegates is 48.

Speaker Pyle: As that constitutes a quorum we will call the meeting to order.

Speaker Pyle: We will now call the roll.

Secretary: I hold in my hand 52 signed attendants for this session. I move you that that constitute the official roll call of this first session of the House.

Dr. C. S. Gorsline (Calhoun): I second the motion.

. . . The motion was carried. . . .

. . . Speaker Pyle delivered his annual address. . . . (Applause).

Gentlemen:

I feel greatly honored to preside at this meeting of the House of Delegates of the Michigan State Medical Society. I assure you that I greatly appreciate the trust reposed in me and it will be my purpose to justify your action. Nowadays we hear a great deal about mergers in almost every branch of human activity, but we should be proud of the fact that the progressive Doctors of Medicine of this commonwealth anticipated this tendency by organizing one hundred and nine years ago to form a society, and as a group it has never lost its identity.

Today this assembly is convened to carry out the wishes of thirty-six hundred physicians of this state. The House of Delegates is the supporting arm and guiding hand of our state organization. Its responsibilities are all inclusive. With it rests the future of the profession in Michigan. It holds in its jurisdiction the honor of medicine in this state. With it is placed the health welfare of the public as well as the individual and collective interests of our members. Your deliberations and actions upon the problems confronting us will have very important influences and will be subjected to the scrutinizing, critical review of the people of this community. They will record progress and beget confidence, or the reverse, depending

upon the way in which you discharge your individual trusts reposed in you by the County Society which has honored you by sending you here. I purposely stress these points because I do not believe that the average member of our State Society realizes the great importance of being a delegate.

As a house we do not deal with the romance or vagaries of medicine. We care not whether the individual physician is of the opinion that a gastric ulcer should be treated surgically or medically. Matters of this kind are handled with more or less debate in the different scientific sections, and although the public interest should, of course, come first, we should do everything in our power to conserve the interests of our individual members. Although we all stand ready to honor those of our members who are along in years and have served nobly, let us not forget the future of the young man, who, after years of study and training, finds numerous agencies constantly making it more difficult for him to obtain remuneration for the time spent in preparation for his life's work. In the past our Council and Legislative Committees have worked diligently so that our noble profession would not be rated legally with those sects who try to exploit the sick by back pushing, bone pulling and incantations. There is, I believe, an element in our profession who believe only in a passive opposition to these sects lest we lose our dignity, but war is never dignified, and I personally believe in a two-fisted, healthy resistance. After all, the general public will benefit, and I am sure the end will justify the means. It would certainly be a dark day for the medical profession and the public if the young physician who has spent seven years of study and training after leaving high school, should be placed on a par with the long haired product of a diploma mill. Our Society has already done a great deal to educate the public, but I am sure it would be well for the proper committees to see to it that the general public be informed as to the qualifications required before a practitioner may use the title "M. D." Surely the title "Doctor" means nothing because the uninformed layman does not know whether the person using this title deals in souls, salves or sophistry.

It is my own opinion that much harm is done by some of our own members because I have occasionally seen that there is too close an association between the regular physician and the irregular practitioner in the matter of consultations and the referring of cases. I presume there is nothing written in our constitution that would prevent any member from associating with the irregular, but I do believe that we, as individuals, should not hesitate to call these errors to the attention of the offender. Possibly some suggestions might come from this assembly to the Council dealing with this subject.

Another matter which I would like to call to your attention is our Constitution and By-Laws. After a hurried reading, I believe they contain a few horses and buggies and long skirts which may impede our progress and obscure our inherent loveliness. I trust your Speaker will be authorized to appoint a committee to revise our Constitution.

I think it would expedite matters greatly if the Speaker had the power to appoint a nominating committee of five members. Nominations coming from this committee would not, of course, prevent any members making nominations from the floor. The office of President-elect might also be created.

Anticipating your patient co-operation in the conduct of this session, I thank you.

Speaker Pyle: This address will be referred to the Committee on the Report of Officers.

We will now call on our state President, Dr. Hirschman, for his address. (Applause).

Mr. Speaker and Members of the House of Delegates:

Inasmuch as it is customary for your president to make a few remarks at the opening of your annual session, I must fall in line with this custom.

The problems which have confronted us during the past year have been principally legislative and the excellent report of our legislative commission fully covers the story of our activities along that line. I am discussing this subject more at length in my address to be presented at tomorrow night's general session. I wish to state, however, that in order to secure the proper attention of our legislators to matters of public health the initiative must not be taken by us, but by non-medical and civic organizations.

The mind of the average legislator cannot conceive of the medical profession having any other than a selfish interest in all proposed laws to raise the standard of

medical service to our citizens. Until they realize that a physician is something more than an individual engaged in making a livelihood, and until they feel that he really is in earnest in his efforts to protect the public from improperly qualified practitioners and so-called healers, nothing which emanates primarily from the medical profession will receive a sympathetic hearing from the law-makers of our state.

I would suggest that some special effort be made to establish contact between our society and the various lay organizations such as chambers of commerce, civic associations, luncheon clubs, fraternal organizations, women's clubs, parent-teachers associations and organizations of our sister professions, the law, engineering and the ministry. With the co-operation of organizations of thinking, intelligent and interested citizens, perhaps we can awaken sufficient interest in the citizenry of our state to stand together for self-preservation in health matters.

One way in which the Michigan State Medical Society can interest the general public in medical matters and therefore awaken them to the menace of being subjected to the ministrations of chiropractors, osteopaths, Christian Scientists and other so-called non-medical "healers" is to give them the opportunity of learning something about medicine and the profession.

In every large center of population as well as the smaller communities who possess public libraries and reading rooms, our state society should assist, as far as it is necessary, the county society in providing medical literature which is written for the lay public. Copies of Hygiea and all of the pamphlets issued by the American Medical Association for the public should be placed on the reading tables of these libraries and the supply constantly renewed. This distribution should be in the hands of a committee appointed by each county society or by their secretary as the case may be.

A number of books have been printed for publication on medical matters which should also be available for loaning purposes. I wish that this matter be given careful consideration. In the meantime, this subject should be brought to the attention of the various county societies and their members through our state journal.

TAXATION WITHOUT REPRESENTATION

In the good old days of the American Revolution this was the slogan for which the patriotic citizens of our young country fought, bled and died. It has been a noticeable fact that while practically every other state society has been represented in the House of Delegates of the American Medical Association by men who represent the large centers of medicine and population in their state, for some reason Michigan has not been equally, fairly or proportionately so represented in that regard.

The Wayne County Medical Society representing nearly one-half of our membership and a county which contains a large medical center, the fourth city in population in this country, has not for many years been properly or proportionately represented in our official delegation to the American Medical Association.

It is time that this representation cease to be made a political foot-ball and justice, fairness and equity be observed. It is hoped that as vacancies occur that Wayne County with its nearly fifteen hundred members be represented by a minimum of two delegates in the future.

The problems of Wayne County are the problems of the state and the state's problems are those of Wayne County. I earnestly beg of you members of our House of Delegates to see that Wayne County is treated more fairly in this matter of apportionment just the same as the State of Michigan is seeking justice in our congressional apportionment in the national House of Representatives at Washington.

I do not wish to burden you at length with matters which will be presented by individual delegates and in various committee reports. There are two or three matters, however, on which a word from your president will not be amiss. I therefore, take this opportunity of speaking upon a subject which is of vital importance to any state medical society and particularly to our own at the present time.

THE SECRETARYSHIP

If I do not dwell upon any other subject to you this morning, the one upon which I am speaking now is one which will deserve your serious attention.

While the secretary and treasurer are elected by the council of our society, I believe that whatever action they may take should be, and properly so, influenced by the wishes and advice of the delegates who represent the various constituent units of our society. Each year by action of the House of Delegates as indicated by the needs of the Public Health and our pro-

fessional activity, the work of the executive officers is manifoldly increased.

The committees, especially the members of the executive committee, editor and president are giving more and more of their time to the society. The number of days taken from their professional work with its accompanying loss of time, and income is increasing. But the sum of all these activities added together would be but a small fraction of the sacrifice of the income which has been suffered by the secretary of our society. The present remuneration of this office is absolutely incommensurate with the demands of the position. From personal contact with the work of our secretary during the past year, I am convinced that the time is near at hand when Michigan must follow the lead of other great medical societies and provide for a full-time secretary.

The present incumbent of this office by reason of his peculiar adaptibility to its many demands, would be an extremely difficult man to replace. One must remember, however, that after all he must earn his livelihood in the practice of medicine. As every member of this society knows when one is forced to absent himself from his professional duties nearly half of the time, a medical practice is soon dissipated and the years of constructive work building up such a practice are wasted. It is a difficult task for any one to serve two masters at the same time and serve them well. The House of Delegates and the council must study the problem of proper compensation for a part-time secretary or arrange adequately for the employment of a full-time secretary without further delay.

THE PRESIDENT-ELECT

Inasmuch as it devolves upon your officers to carry on, with the assistance of the appropriate committees, the workings of the society, the selection of these officers should be made at all times with the best interests ofthe society paramount.

When the Michigan State Medical Society wishes to honor one of its members by elevating him to the highest office within its gift, this should be literally true. The office of president of this organization is far from being an ornamental position, nor is it a shelf upon which to place what remains of a member when his active professional days have definitely declined. The man whom this society honors by placing upon his shoulders the responsibility of guiding its activities during his term of office must be prepared for many personal and professional sacrifices.

Inasmuch as this is primarily a *medical* organization, he must have achieved some distinction in the *practice of his profession.* He must also be possessed of a considerable amount of energy and executive ability and must be physically able to comply with the many demands made upon him which involves considerable travel and many absences from his home. He must be willing at all times to accept constructive criticism and at the same time must not allow opposition or lack of co-operation to discourage him. In order to give the best service to this organization, its president must be a man who is more or less in touch with all the activities of organized medicine and particularly those of his state society. In order to produce a more smoothly running machine and preserve the continuity of action, purpose and progress, the Michigan State Medical Society should follow the precedent of the American Medical Association and several of our sister states societies.

Our constitution and by-laws must be amended so that a president-elect can be chosen one year before his term of office is to begin. The president-elect should be invited to attend all the meetings of the executive committee and of the council and all the other important conferences during the year preceding his installation. In this way he can become thoroughly familiar with the aims, purposes and problems of the society as well as the operation of the various functions and activities of the organization in order that he may be thoroughly trained and prepared for his activities as the presiding officer.

The step necessary for this change in our organization should be instituted at once in order that a president-elect may be chosen at the next annual session.

THE EX-PRESIDENTS

As has been said above, the members of this organization who have achieved the distinction of acting as its president have acquired a large fund of knowledge, information and experience which is of great value to the society. To be honored by this organization by being called to preside over it entails a great responsibility on the individual. There is no reason why this experience should be lost to the organization after his term of office has expired. There is no desire on my part to advocate any precedent for continuing office holders in office. It is suggested,

however, that the services of the ex-president, made valuable by previous contact, be utilized by the society if not in an active, at least in a consulting capacity.

It is proposed, therefore, that the formation of a board of ex-presidents be considered with the idea of utilizing their influence and experience in matters involving ethics, policy, finance or legislation, should at any time the officers or council of the society feel the need of such support.

THE VICE-PRESIDENTS

The vice-presidents of our society should be selected with as much care as the president-elect. While it is desirable and oft times politic to have various sections of the state represented geographically, it is far more important to select men who are fully qualified to fill the presidential chair when and if the occasion should arise. The vice-presidency should be something more than a position of honor and expectancy. Each vice-president should be actively engaged in some one of the activities of the society. It might be desirable to divide the state into four sections and have one of the vice-presidents in charge and to act with the group of councilors in his section, in all matters which are purely sectional in character.

As our post-graduate activities increase it might be desirable to have the vice-president take active charge of these activities in his section of the state. During the past year your president has requested the presence of one of the vice-presidents at each executive and council meeting in order that he might be familiar with the workings of our organization. It is hoped that this will continue. I believe that it would be extremely desirable to make each vice-president the chairman of one of the important committees. In this way, each vice-president would become an active unit of our society organization and become a functioning official instead of being part of the ornamental background.

MEDICAL HISTORY OF MICHIGAN

This monumental piece of historical value has been under way for several years by a hard working committee of our organization. Without disparaging in any way, the work of the other committeemen, this committee does not differ from many others in that the major portion of the work is carried on the shoulders of its chairman. The collection of material and editing of the same, involving the inspiring story of medicine in Michigan has been carried on by one of our ex-presidents, who while retired from the active practice of his profession, refuses to become inactive. I refer to the task of preparing the medical history of the profession of our great state. Dr. C. B. Burr is doing an outstanding piece of work which will preserve intact the story of Michigan's place in the medical world from the time of the first pioneer to the accomplishments of the present day. This labor of love on the part of Dr. Burr has placed our profession forever in his debt and will keep his memory ever green in the hearts of his profession for all time to come. I sincerely hope that the first volume will be in the printer's hands before very long and that each of us will be able to number among our treasured possessions a complete set of volumes of this record of the achievements of our medical forefathers in Michigan.

In conclusion I trust that the deliberations of this House of Delegates will be productive of much that is constructive and beneficial not only to our own organization but to the people of Michigan who have intrusted their lives and their well being to our hands.

I wish to thank all of you who have assisted and collaborated in making my administration productive of much that will be of value to our organization and its efforts. I bespeak for my successor the same kindly and sympathetic support and co-operation that it was by pleasure to receive from one and all during the year just closed.

. . . President Hirschman presented his prepared annual address. . . . (Applause).

Speaker Pyle: The address will be referred to the Committee on Officers' Reports.

Secretary: When one goes back in the history of organized medicine, and especially in the period of the reorganization of the American Medical Association, there are two outstanding names. One is that of Dr. George H. Simmons, and the other is that of Dr. McCormack. Dr. McCormack has gone to his eternal reward, but our Michigan State Medical Society is fortunate to have Dr. McCormack's son as our guest and as a participant in our program.

It is my particular pleasure to introduce Dr. Arthur McCormack, Secretary of the Kentucky State Medical Society and the State Department of Health of Kentucky. (Applause).

Dr. Arthur McCormack: I am happy to be

present. We are fortunate in Kentucky, just as you are; we have a fundamentalist as our President this year, Dr. Haines. We have gone back to the first principles, as you have done. When I received the delightful invitation to come to this meeting Dr. Haines was good enough to tell me that I must come up immediately and find out exactly how the thing was done. I was particularly glad to do this because I was in the conference of the State Secretaries in the American Medical Association and Dr. Warnshuis has done a lot of my training in medical economics and those larger affairs of medicine that have gone to make our organization in Kentucky successful.

I was glad to come here and to see you. I am an alumnus of Detroit and the distinguished faculty of that institution has been very good to me, showing the generosity of Michigan.

After all, you Michiganders owe us a lot of gratitude because you would have been in Canada if it hadn't been for us down there. We made you citizens of America and we have a right to come up here and find out anything that is good for us. I am very happy, indeed, to be here and watch you in these deliberations. I do not think I ever heard a finer presentation of a Presidential message than was given here.

The things that Dr. Hirschman has talked to you about so practically are the things that are in our hearts. It wasn't fair for us doctors to be giving so much of ourselves and our time, for so many years, to everything that came along and yet not to realize the change in the economic situation which makes it impossible for a man to give service to a practical organization, such as the medical organizations are today, without compensation.

I never hesitate to "butt" in on medical organizations because I always feel so natural when I am among doctors. I feel perfectly free to talk about what is in my heart. I do not think it is right for me to take up your time without saying some of the things that my extensive observational privileges have made me feel full of.

You have had the outstanding state secretary of the United States in your organization for many years. He has been effective and he has done such good work so you do not want to impose on him. When you get started on the secretary business do not try to get a layman to run your job. I do not think we are yet non compos mentis, or at the stage when we need a full time lay secretary. I am told they have to find out everything they know from you in the first place. It is easier to find somebody who has been raised right, like this chap has over here (referring to Dr. Warnshuis) than it is to get one who hasn't had a medical background and who starts out by embarrassing us constantly by all sorts of complications. I have seen that happen in almost every state of the Union. There are many varieties of them. Some of them succeed in accomplishing certain results provided somebody like you (again referring to Dr. Warnshuis) gives the time to coaching them and tells them what to do. If they go themselves it is like putting a greenhorn on to steer a ship. They will run on the rocks and the profession will be humiliated.

I have been preparing for a number of years an article that I will publish some day in our Journal. It is on the genus medicus extinctus. We doctors have been, and our work has become very much complicated. We first started out with the nurses and the technicians and the other systems. We have so many of them that it is only a question of a generation or two until every one of them will start practicing in medicine. You have to remember that all the time.

If the fellow that is doing the work is the one that learns the work, and if we let him do it we become executives. After a little while they are going to be lay executives practicing medicine and we are going to be among the technicians and will go around doing our little part and we will develop into these tremendous specialties that are too frequently occupying our time and are circumscribing our vision.

It seems to be important to us to remember that we are the heirs of the ages, that the whole responsibility for scientific medicine and public health is on our shoulders and that in proportion as we retain control and do the job ourselves will we succeed in that large vision of making ourselves the human engineers who are going to keep people well in the future. Our big job is going to be as human engineers guiding them into good health as far as it is possible to do it. We are going to have to reverse our methods, therefore, in some respects. Let us not revise them by giving away our whole heritage to others and have us merely looking on as supporters in that honor.

It is a great privilege to be here and I shall take back to Kentucky from this meeting, I know, many suggestions that will be of a great deal of value. I congratulate you on the near completion of your history. It is a glorious history and I know how gratified and stimulated we will all be by having the privilege of reading it. (Applause).

Speaker Pyle: We will now listen to the annual report of the Council. Dr. Stone.

Dr. R. C. Stone: It is not my intention, this morning, to bore you or to take up your time with any remarks. Your program is full. You have started a little bit late. According to the custom which was inaugurated last year I am going to ask our Secretary to give you the report of the Council. (Applause).

TO THE HOUSE OF DELEGATES:

The Council transmits this, its Annual Report.

During the past fiscal year your Council has been mindful of the expressed and implied wishes of the House of Delegates. In official activity the Council has sought diligently to discharge its obligations to our membership as well as to the citizens of our Commonwealth. It submits the following statements, reports and recommendations:

FINANCIAL

The financial receipts and expenditures for 1928 were duly reported in the Journal that imparted our bonded auditor's report. On January 1, 1929, our reserve funds were: Society, $27,698.75, and Medical Defense, $12,841.80. This present year will witness a very material increase

in expenditures by reason of an expensive legislative campaign, the need of additional help and an increase in cost of the Clinical Conferences that have been conducted. The broadening scope of our society activity has likewise entailed added expense. Your Council feels that these expenditures have resulted in personal benefits to our members and therefore are wholly justified. The policy has been that actual expenses of individuals are compensated. Your Council assures the House of Delegates that it is ever alert to keep expenses at the lowest possible figure.

MEMBERSHIP

Our membership on August 31, 1929, was 3,327, represented in the following component units:

Alpena	14	Macomb	38
Northern Michigan	14	Manistee	12
Barry	12	Marquette-Alger	38
Bay-Arenac-Iosco	61	Mason	9
Berrien	42	Mecosta	20
Branch	7	Menominee	11
Calhoun	118	Midland	7
Cass	8	Monroe	34
Chippewa-Mackinac	15	Muskegon	67
Clinton	16	Newaygo	11
Delta	22	Oakland	108
Dickinson-Iron	7	Oceana	8
Eaton	19	O. M. C. O. R. O.	
Genesee	133	Otsego	
Gogebic	26	Montmorency	
Grand Traverse-		Crawford	
Leelanau	25	Oscoda	
Gratiot-Isabella-		Roscommon	
Clare	28	Ogemaw	10
Hillsdale	20	Ontonagon	6
Houghton	41	Ottawa	26
Huron	10	Saginaw	62
Ingham	89	Sanilac	6
Ionia-Montcalm	36	Schoolcraft	5
Jackson	76	Shiawassee	30
Kalamazoo	115	St. Clair	44
Kent	189	St. Joseph	15
Lapeer	16	Tri	21
Lenawee	34	Tuscola	25
Livingston	15	Washtenaw	121
Luce	10	Wayne	1,390

POST-GRADUATE CONFERENCES, CLINICS AND COURSES

Arrangements and plans are perfected to conduct one, and in some instances, two Post-Graduate Conferences in each Councilor District during this present year. These conferences continue to receive the interest and appreciation of our members.

In June, a two-day Clinic was conducted in Detroit. The program consisted of out-of-state noted medical speakers.

In May the first Post-Graduate Course, under the auspices of the State Society and the Department of Post-Graduate Medicine of the university, was given in Detroit. For this four weeks' course provision had been made for a class of thirty, the attendance was forty-five. In addition, Post-Graduate courses in Roentgenology and Serology were given at the university. This year witnessed a material advancement in the development of plans that lead toward the completed establishment of a school of post-graduate medicine that will accord to our members the fullest opportunity for the pursuit of post-graduate studies.

Your Council feels strongly that the efforts directed towards enhancing and broadening state opportunities for post-graduate work is of outstanding importance in our society activity. It is a call and demand of the times. The public is insistent upon receiving the services of doctors abreast of scientific knowledge and who are capable of providing to the fullest degree that type of service. Our members must render this high-grade service. It is the duty of our society to make it possible for our members to remain abreast of medical progress at a minimum expenditure of personal funds and time. It is toward that end that your Council and officers are expending their thought, efforts and time. Your Council urges, most intensely, that our members avail themselves of these opportunities for professional advancement, thereby avoiding the formation of criticisms based upon inefficient professional services.

LEGISLATION

Your Council directs attention to the reports that have appeared in several issues of The Journal relative to our experiences during the session of the 1929 Legislature. We draw particular attention to the Legislative Commission's final report transmitted to you during this session. Your Council recommends that this report be given extended and careful consideration.

HONORARY MEMBERS

The Council nominates the following Honorary Members:

Dr. R. N. Eccles, Blissfield, Lenawee County.

Dr. A. M. Hume, Owosso, Shiawassee County.

Dr. C. B. Wasson, Bellevue, Eaton County.

Dr. H. D. Robinson, Manistee, Manistee County.

EXECUTIVE COMMITTEE

The Executive Committee of the Council has continued to hold monthly meetings and has thereby kept in intimate contact and advised in the work of our officers and committees.

SOCIETY ACTIVITY

The Council submits for information and without comment, because reports have appeared from time to time in The Journal, the following citation of the scope that has been characteristic of our society work during the past year:

1. Joint Committee on Public Health Education.
2. Medico-Legal Defense.
3. Annual Conference of County Secretaries.
4. The Journal.
5. Bureau of Public Information and Publicity.
6. Organizational Problems of County Societies.
7. Conference with and Representation upon the State Crippled Children's Commission.
8. Co-operation with Standing Committees and Especially with the Committee on Civic and Industrial Relations.
9. Advisory Conferences with the State Department of Health.
10. Advisory Relationship with County Clinics for Crippled Children.
11. Bureau of Inquiries for Members.
12. Details of Annual Meeting, Section Programs, Commercial and Scientific Exhibits.

It will be perceived from the above enumeration that your State Society work includes effective contact with a wide field of state and national activities that impinge upon medical practice in Michigan and in which our members have a vital and personal interest. The assurance is given that in all these relationships the motive has been to conserve and enhance our members' welfare. Your Council is of the opinion that never before has our Society reflected such a broad and important scope of organizational work, or achieved more for its membership personnel.

MEDICAL ECONOMICS

The Council has sought to remain in close contact with and to support our American Medical Association in its work that deals with national and state medical problems. We are lending all possible assistance in national legislation. We are endeavoring to fully co-operate with the Committee on the Cost of Medical Care and we unite, without reservation, to advance the work of the several councils and bureaus of the American Medical Association. The opportunity is here utilized to approve and commend as well as to express appreciation for these manifestations that our parent organization, the American Medical Association, is exhibiting in its work for the profession as a whole and the doctor as an individual.

The Council sincerely and urgently recommends that all of our members become Fellows of the American Medical Association. It would be a distinction to which we could point with just pride if Michigan would support our parent organization by recording 100 per cent Fellowship in that national body that so well serves the members of the profession of medicine. Your Council makes this recommendation with utmost sincerity and earnestness and trusts this House of Delegates will record some specific action thereon.

COUNTY SOCIETIES

The Council feels strongly that County Societies must assert more emphatically the purposes for which they exist and to rightly assume their inherent rights to local leader and directorship in all matters pertaining to medical practice and public health.

With regretful concern do we note the relinquishment of this leadership to self-constituted and dis-related groups that are trespassing upon and ursurping the rights and prerogatives of County Medical Societies. Hospital staffs, clinic groups, independent organizations and lay individuals are invading County Society functions and institute their activities in a most dis-related and, at times, arrogant manner. The situation presents a serious problem and danger. We quote the following from Secretary West's annual report rendered at the 1929 session of the American Medical Association in Portland:

THE NEED FOR COMPACT AND EFFICIENT ORGANIZATION

"The medical profession, in common with all other groups of society, is feeling the strain of a great transitional stage in the life of our country. In some ways physicians are being subjected to greater pressure and stress than any other group. The tendency of government toward paternalism, the restrictions imposed by legislative enactments and by bureaucratic regulations, the establishment of great funds and foundations ostensibly benevolent in character interested primarily in medical care, the trend of modern business with its installment plans and high pressure salesmanship, the propagation of half-baked theories, semi-truths and positive misinformation through the public press and even through periodicals designed for physicians, a flood of loose talk without regard for fact and, it may be, the disposition on the part of a minor element of the profession to commercialize the practice of medicine and to depart from ideals and traditions, established through the ages, that have made possible the progress and the achievements of scientific medi-

cine—all these are factors in the situation that exists today in which the medical profession finds itself the object of much criticism that is not deserved and the recipient of many suggestions for its conduct. Much of this may be helpful, but a great mass represents considerations which physicians know are unpractical or even dangerous.

"There has never been a time when there was greater need for compact and efficient organization of the physicians of this country than exists now. Our own plan of organization is comprehensive and, in most particulars, entirely sufficient if put into proper operation and carried out with reasonable efficiency. This cannot be done if the dissipation of effort and the conflict of interest occasioned by the existence of a multitudinous number of independent medical organizations are to be continued. The number of these independent groups can be materially reduced with benefit to the cause of scientific medicine and, consequently, with benefit to the individual physician and to the public. They are maintained for the most part by our own members who could contribute more to the common good through the county medical society, the state medical association and the American Medical Association as the fundamental and necessary organizations of physicians in the United States. The inordinate number of medical meetings occasioned by the existence of so many societies, the frequency of hospital staff meetings, on which attendance is compulsory under rules established by other than those who must attend, glorified as many of these staff-meetings are into scientific societies, will sap the vitality of the county medical societies and make it impossible for the regularly organized profession to deal with problems that are pressing for solution and that cannot be controlled through any other agency.

"In one city with a medical population of less than five hundred, thirty-three meetings are scheduled in one month, twenty-nine of them staff meetings. In another city with less than nine hundred physicians, including non-members, twenty-three meetings are scheduled in one week, eight of them staff meetings. These examples are typical of a national situation.

"In practically all instances, the members of independent organizations are the members of the component county medical societies. The work of one group must be done by the very men that must be depended on by the other. Why cannot the regular organization meet all the needs of its members, since whatever is done must be done by them? If there is need for special programs, why can they not be arranged for by the county society and the state association and the national organization as part of their own broad program of work?

"There are problems arising out of more or less revolutionary conditions of the times that cannot be effectively solved except through the agency of organized medicine. There are others that will be solved only through the processes of evolution, although efforts are constantly being made to deal with them by the application of revolutionary methods. There is great need for well considered action on the part of a unified profession looking toward the solution of those problems that are susceptible of solution through human agency. It is equally important that there shall be no ill considered action in attempting to deal immediately and finally with those problems that will be worked out only through the process of time. There is need also, for combatting the efforts of agitators who set up windmills on which they can break their lances, who create great furor over pseudoproblems and thus detract attention from important matters that should receive earnest and persistent consideration.

"The urgent demand of the time is for unified action and for expression through a great voice that will speak authoritatively for the entire profession of medicine in the several states and in the United States. This demand can be properly met through unity that is possible only as far as the profession is compactly organized. Its attention must be centralized, without undue division of fealty and without unnecessary waste, on those responsibilities and duties that naturally devolve on the profession in its organized capacity, and that heretofore have always been discharged with credit and honor."

Your Council is therefore constrained to most earnestly recommend that all our members renew their loyalty to their County Society. It is a pressing responsibility of every delegate, when he returns to his County Society, to present this problem an dto not desist until his society has fully reasserted itself and assumed with renewed energy local leadership. Your Council calls upon all members to evidence their fullest loyalty to their County Society and to cause their remaining activities to be subservient to their local society. Your Council further recommends that a proper resolution be adopted expressing the desirability that County Societies take such action as will bring the County Society into leadership in all the problems and activities related to the practice of medicine and public health welfare in its county. Such assertiveness is imperative to our professional and society interests.

CONCLUSION

Your Council reaffirms that it recognizes the responsibility that is reposed in it. The Council discharges its duties with but one guiding motive—our collective and individual interests to the honor of our profession and the welfare of the public.

Respectfully submitted by:

THE COUNCIL.

R. C. STONE, *Chairman.*
F. C. WARNSHUIS, *Secretary.*

Speaker Pyle: This report of the Council will be referred to the Committee on the Reports of Officers.

You will note that the next order of business is the appointment of Reference Committee. According to our constitution there should be three committees and I will appoint them as follows:

REPORT OF OFFICERS

William J. Cassidy, Wayne.
W. J. Smith, Wexford-Kalkaska-Missaukee.
Robert Baker, Oakland.
C. N. Bottum, Marquette-Alger.
F. T. Andrews, Kalamazoo.

REPORT OF THE COUNCIL

C. F. McClintic, Wayne.
George Hafford, Calhoun.
F. Reeder, Genesee.
C. R. Keyport, Oscoda, Roscommon, Ogemaw.
E. F. Crummer, Bay, Arenac, Iosco.

MISCELLANEOUS BUSINESS

Milton Shaw, Ingham.
S. T. Bell, Alpena.
William C. McCutcheon, Cass.
W. Elwood Tew, Gogebic.
W. B. Holdship, Huron.

The next order of business is the election of the Nominating Committee.

Dr. A. E. Catherwood (Wayne): I place in nomination the name of Dr. Cassidy for the Nominating Committee.

Dr. Gorsline: I want to nominate George Hafford of Calhoun.

Dr. C. D. Munro (Jackson): I nominate Dr. J. J. O'Meara.

Dr. C. Moll (Genesee): I nominate Dr. Ellet of Benton Harbor.

Dr. Harry F. Dibble (Wayne): I nominate Dr. Keyport of Oscoda.

Dr. Gorsline: I move the nominations be closed.

Dr. C. F. McClintic (Wayne): I second the motion.

Dr. Gorsline: I would add to that that the Secretary be instructed to cast the ballot of the House for the five gentlemen.

Dr. McClintic: I'll second that.

. . . The motion was carried. . . .

Secretary: Your Secretary does so cast the ballot of this House for the Nominating Committee to be composed of: Cassidy, Hafford, O'Meara, Ellet and Keyport.

Speaker Pyle: The Chair will declare the Nominating Committee elected as stated.

We will now listen to the reports of the various committees. There is the Committee on Medical Education.

Dr. Biddle: I move the report be received as printed in the program.

. . . The motion was seconded and carried. . . .

Speaker Pyle: Next we will hear from the Committee on Public Health.

Secretary: Does that mean that the reports are referred to the Reference Committee?

Speaker Pyle: They will be referred to the proper committees.

Dr. R. D. Thompson (Kalamazoo): I move you that the report of the Committee on Public Health be accepted as printed.

. . . The motion was seconded and carried. . . .

Speaker Pyle: We will next hear from the Committee on Tuberculosis. (No member of the Committee was present).

Next is the Committee on Civic and Industrial Relations.

Secretary Warnshuis: Dr. Collisi is the chairman of that committee. He is not a member of the House of Delegates. Dr. Dibble, who is a member of that committee, is a member of the House of Delegates.

Dr. Dibble: I spoke to Dr. Collisi on that this morning. He has that report and is supposed to present it here.

Dr. Harrison S. Collisi: The report has been previously printed in the State Journal and it also appears on page 39 of this program. It is rather long and as chairman of the committee I would be glad to answer any questions that anyone has to ask with reference to the report, if there is any question in your minds on it.

Speaker Pyle: Is there any discussion, or are there any questions that you would like to ask the chairman of the Industrial Relations Committee, Dr. Collisi?

Dr. McClintic: I move the report of the committee be accepted as printed in the Journal.

. . . The motion was seconded and carried. . . .

Dr. McClintic: Also, as refers to the report of the Tuberculosis Committee, I would like to have unanimous consent to refer that report to the proper committee.

Speaker Pyle: There is no objection to accepting the report of the committee as printed.

Dr. McClintic: Then I move that the report as printed be referred to the Reference Committee.

. . . The motion was seconded and carried. . . .

Dr. Hirschman: I would like to say a word here. I would like to take this opportunity of expressing my personal appreciation, and I think that could include the appreciation of the membership of the State Medical Society, for the wonderful piece of work done by the Committee on

Civic and Industrial Relations. You must all realize that they have done one of the outstanding pieces of work for the profession in many years. Those of you who have not read that report, I would advise you to do so. I would like to take this opportunity of proposing a vote of appreciation and thanks for the excellent piece of work done on behalf of Michigan this year.

Dr. J. Earl McIntyre (Ingham): I will support that motion. I will move that a vote of appreciation be extended to the Committee on Civic and Industrial Relations for the wonderful work they have done.

Dr. Gorsline: I second the motion.

. . . The motion was carried. . . .

Speaker Pyle: We will next hear from the Committee on Venereal Prophylaxis.

Secretary Warnshuis: There is no report, only a communication from the chairman of the committee. It would be entirely in order to refer that communication to our Reference Committee on reports of committees.

Speaker Pyle: That report will be so referred.

Next we will hear from the Committee on Medical History, Dr. Burr.

Dr. C. B. Burr: The report has been printed and may I ask that it be accepted as printed?

Dr. J. H. Dempster (Wayne): I make a motion that the report of the Committee on Medical History be accepted as printed.

Dr. F. T. Andrews (Kalamazoo): I second the motion.

. . . The motion was carried. . . .

LEGISLATIVE COMMISSION

Speaker Pyle: We will now listen to the report of the Legislative Commission, Dr. Kiefer.

Dr. Guy L. Kiefer: Mr. Speaker and Delegates: Your Legislative Commission submits this report. This is the final report.

Following the creation of this Commission we have from time to time transmitted reports that reflected our work. The story of our legislative experience during the session of the Legislature has been told. It now remains for us to formulate certain conclusions and recommendations for consideration and action by the House of Delegates.

Conclusions: Our contacts and experiences impel us to set forth the following:

1. Legislative enactments governing the practice of medicine and surgery are of but passing concern to the members of the Legislature. Legislators are so uninformed in regard to medical educational requirements that they do not differentiate or judge between principles, facts, and factors that govern medical practice. The claims of certain groups are as impressive to them as are the truths of scientific medicine and the laws of preventive medicine.

2. For reasons undiscernable legislators assume and hold that when our profession inspires, recommends, or seeks legislation that we are doing so for selfish and ulterior purposes. We are so accused and our representatives are questioned and frequently ignored. We are also credited with being biased and intolerant as well as perpetuating a medical trust.

3. Legislators sponsoring cult legislation discharge their commissions by aggressive lobbying and trading of votes. Their inspiring motive seemingly is to obtain the passage of their bills regardless of their provisions or effect upon the health and welfare of the people. They are irresponsive to and even completely ignore submitted facts and authoritative statements.

4. Doctors, in some instances, have lost the confidence and acquired the antagonism of the public by overcharging for inferior or minor services. Such individual cases have reflected this attitude of the public and legislators to the entire profession.

5. Doctors, on the whole, fail to concern themselves with legislative problems that are of vital concern to them and their practice. They neglect establishing effective contacts with their senators and representatives. Upon numerous occasions when your Commission requested individual assistance we were met with evasive excuses and disinclination to aid.

6. Most of our County Societies failed to exercise their organizational influence. Local Legislative Committees half-heartedly discharged their duties and some there were that never functioned.

Your Commission might continue at length in citing incidents and experiences encountered that would be self-explanatory as to why proposed legislation is difficult of enactment and why our status in the Legislature is so nearly negligible—we refrain from doing so. Your Commission does, however, desire to bluntly set forth the following possibilities for informative purposes and as a warning as to what may be expected from future Legislatures if our members continue to pursue their present course:

1. Osteopaths will obtain legislation granting them all the rights to practice medicine, surgery and obstetrics under an independent board and with low educational requirements. This will open the door to hundreds of incompetents who will rush to our state and prey upon an unenlightened public.

2. Chiropractors and other cults will gain recognition with ever-increasing practice privileges.

3. Optometrists, chiropodists and similar present-day groups will gain certain medical practice privileges.

4. Hospitals will, by legislation, be compelled to admit patients under the care of cultists.

5. Cultists will gain public office and supervise, through such office, health preventive measures and methods.

Your Commission disclaims any charge of exaggerated apprehensiveness. We are positive in our conviction that such eventualities are at our doorstep. The door will be opened wide unless we, as individuals and as an organization, arouse ourselves to greater aggressive efforts. These cultists and aspiring pseudo-scientists are organized, active, persistent and determined. They contribute large sums to finance their quest and employ shrewd attorneys and lobbyists in their endeavor to secure legislative recognition.

Your Commission desires to make the following general recommendations for your consideration:

1. That the Legislative Commission's report be accepted and the Commission be discharged.

2. That the president appoint a new Legislative Committee, by and with the advice of the Council, with the State Secretary as an ex-officio head of the committee.

3. That the Legislative Committee be instructed to conduct a lay educational campaign and comply with the provisions of our by-laws.

4. That the Legislative Committee be instructed to attempt to secure at least two representatives of the profession in the Senate and two in the House.

5. That the Council request the Joint Committee on Public Education to arrange a series of talks related to Medical Legislation and impart them through their channels of public contact.

Your Commission respectfully tenders these recommendations with uttermost urgency, recognizing fully that to fail and not assume such aggressiveness will invite the realization of our prophecy.

This is respectfully submitted and signed by the entire Commission.

Submitted by:

GUY L. KIEFER, Chairman.

C. F. McCLINTIC, J. B. JACKSON.
W. H. MARSHALL, J. W. McINTYRE,
J. W. SUNDWALL, F. C. WARNSHIUS.

Dr. J. D. Brook (Kent): There is altogether too much meat in the Legislative Commission's report for us merely to accept it and place it on file.

Therefore, I move you that this report be referred to the proper committee with a request that we have a report from that committee at a subsequent meeting of the House.

Speaker Pyle: That is so recorded and I will impress on the committee to review it properly. There will be no motion necessary.

A. M. A. DELEGATES

We will now listen to the report of the Delegate to the A. M. A.

Dr. C. Moll (Genesee): Mr. Speaker and Members of the House of Delegates: Your delegation wishes to advise that the complete report of the proceedings of the eightieth annual session held in Portland, Oregon, on July 8 to 12, can be read in the issue of the Journal of July 20 and 27. We earnestly desire that every member of the Society read that report. We do not care to take the time here to do that, but we refer you to the most excellent abstract made of these minutes and published in the September issue of the Journal of your State Society.

There are, however, a few sidelights that are not published in the Journal, and reactions of the laity to our deliberations that are not only of interest, but should be a source of diligent thought and action and study on our parts.

I wish to read to you some quotaitons taken from the Portland papers during our session. I would say that never was a session of the American Medical Association so well represented in the light of the press of the country. The Associated Press had a special representative there and the Chicago Tribune had one, and there were one or two representatives of New York publications.

One of the things that caused a great deal of comment and quite a reaction was Dr. Thayer's opening address. I just wish to quote some of that:

"When in a country like ours the national government attempts to legislate for the whole country as to what we may or

may not eat or drink, as to how we may dress, as to our religious beliefs, or as to what we may or may not read, this is to interfere with the rights which are sacred to every English-speaking man. This is no longer a republican government; it is a tyranny."

It so happened that Dr. Wilson, who is the general secretary of the Methodist church board of temperance, prohibition and public morals of Washington, was sojourning in Portland at that time. That afternoon the Portland newspapers came out in large headlines, "Dr. Wilson attacks Dr. Thayer; charges he is Wet Booster. . . . The doctor replies to the doctor today on prohibtion! Dr. William S. Thayer, president of the American Medical Association, holding its annual convention in Portland, opened the sessions of the House of Delegates of that body Monday with a stirring attack on intolerance and flayed prohibition.

"Dr. Clarence True Wilson, general secretary of the Methodist church board of temperance, prohibition and public morals, of Washington, D. C., in Portland for the summer, today struck back at Dr. Thayer, called him a 'wet' and charged him with being 'unpatriotic.'

"It's the Doctor of Divinity versus the Doctor of Medicine, with both men champions in their chosen fields.

"Dr. Clarence True Wilson—the Doctor of Divinity—prepared this statement for The Portland News, replying to Dr. William S. Thayer—the Doctor of Medicine—and challenging him to debate:

" 'Dragging the legal and political question of prohibition into an annual address before the American Medical Society is a questionable proceeding, unpatriotic and out of the question.' "

Then he goes on with a lot of other things like that. The reply was in the paper the next day as follows: "The American Medical Association stands unanimously with its president, Dr. William S. Thayer, of Baltimore. So far as the nation's greatest doctors are concerned, Dr. Clarence True Wilson, chairman of the Methodist church board of temperance, prohibition and public morals is 'out'.

"This was the situation Wednesday at the continuation of the doctors' annual convention here, following a red-hot meeting Tuesday afternoon when Dr. Wilson's attack on Dr. Thayer came in for rough handling on the floor of the House of Delegates of the Medical Association.

"By a unanimous vote the House of Delegates adopted the following committee report:

" 'The committee especially commends and endorses the sentiments expressed by President Thayer concerning legislative enactments that are inimical to the best interests of the medical profession and public, by restricting medical men as to what and what not shall be prescribed for the relief of human ills.' "

I also wish to present what I later on clipped from the Portland Journal editorial page:

"The impromptu debate, if it may be called that, between Dr. William S. Thayer, president of the American Medical Association, and Dr. Clarence True Wilson, general secretary of the Methodist board of temperance, prohibition and public morals, is interesting and informative.

"Dr. Thayer represents the very high type of intellect. The emotional is submerged. He is by training a searcher for truth. It is his profession. He is not politically minded; few doctors are. He sees what he believes to be a great menace to American liberty; he understands history well enough to know that the English-speaking peoples have always, sooner or later, rebelled against tyranny. To him, prohibition is tyranny because it is interference with what he believes are his rights.

"Dr. Wilson is a different type. His appeal is chiefly emotional. He is a pastor; he is deeply religious. He carries his message to the people of the churches. Like many great leaders of his type, he is without tolerance for anyone who disagrees by the slightest margin with his particular prohibition views. If you do not accept his doctrine of prohibtion, then you are a wet; you must be in the pay of the brewers; you are unpatriotic! Call out the marines!

"Both Dr. Wilson and Dr. Thayer are strong characters, though they are as far apart as the poles. Both are fighters, both are plain spoken. Dr. Thayer understands his history better than Dr. Wilson, but Dr. Wilson would have the greater appeal in a public meeting; he would sway more people. And both men are following to the chalk line the beliefs and principles that they think right; both are honestly devoting their lives to a cause—Dr. Wilson to prohibition, Dr. Thayer to the relief of human suffering."

Dr. Morgan, the President-elect, in his speech of acceptance, dwelt quite largely on the high cost of medical service and also

on advertising activities. Apropos of this I clipped this from one of the Portland papers written by Gordon H. Cilley. Mr. Cilley, after a thorough newspaper experience, was John Wanamaker's advertising manager for 16 years, and later advertising counsellor to Gimbel Brothers.

"The code of ethics of the medical profession has, since 400 B. C., had a considerable resemblance to the set ways of a stone wall. It began with the oath of Hippocrates, under which every physician is bound to honorable and moral conduct, and which is in a sense interpreted to mean that no physician shall advertise himself. At any rate, that is the defense that is made by the Chicago Medical Society for the expulsion of one of its most brilliant members a few weeks ago. There was a high old row about it, with the result that now, after 2,300 years, the stone wall may begin to move. The doctor in question had allowed his name to become connected with a semi-charitable clinic that rendered very low-priced medical service to the poor, and advertised that it did so. That is where they caught the doctor. He had violated ethics. Out with him! But that is not the last of it. The practice of medicine is one of the most intelligent, if not THE most intelligent of all the professions. Doctors are highly educated, they know a lot about human nature, and most of them are courageous. Some of them now are speaking up and saying that the Chicago episode was a piece of old fogy nonsense, and that the ethics of 400 B. C. have nothing to do with the march of progress and the cure of the human body of 1929. If a group of good doctors can get together and pool their affairs, their money and their skill, and can carry on a low-priced business, healing the sick among poor folks—is it ethics to prevent them? Curiously enough, it has been only 20 years since the banks wouldn't advertise. They held that it was dangerously undignified. But nowadays some of the best advertising that is printed comes from banks and trust companies, giving excellent advice to people about how to take care of their money. They print it in the newspapers, and do a lot of good, and after awhile, the doctors will do the same."

These are but a few of the many newspaper abstracts that appeared in the press of the country at that time. At no time in the history of organized medicine has there been so much scrutiny by critical and on the whole not an unsympathetic public press as today. It behooves all of us to make these impressions, or other individual ones.

It is only by action and active co-operation that the members of our country can benefit. The American Medical Association can carry on its high ideals only in that way. (Applause).

Speaker Pyle: That is a novel and interesting report and it will be referred to the proper committee.

We now come under the caption of new business.

. . . Resolution presented by Dr. Biddle to be reported on later in the sessions. . . .

. . . Invitation, through Dr. Gorsline, to attend the meeting of the Industrial Physicians and Surgeons. . . .

. . . Introduction of resolution by Dr. J. D. Brook to be reported on later in the sessions. . . .

. . . Introduction of resolution by Dr. William C. McCutcheon to be reported on later in the sessions. . . .

. . . Introduction of resolution by Dr. Moll to be reported on later in the sessions. . . .

. . . Announcements. . . .

Speaker Pyle: Is there any other business, gentlemen, to come before us at this time?

Dr. Charles E. Dutchess (Wayne): Following our meeting at Lansing, which was two years ago, a committee was appointed to investigate the taking of paid patients at University Hospital. Their report was published later in the State Journal. I wish to inquire if any provision was made by the Council or any other branch of our Society for correcting the conditions which were complained of in that report.

Speaker Pyle: Dr. Stone, can you answer the gentleman's question?

Dr. Stone: I know of no provision other than the recommendations which were made by the committee. I understood that the University officials have in mind a means of correcting it to some extent. Just how far they have progressed in that I am not at all certain.

Speaker Pyle: Are there any other members wishing to discuss this inquiry?

Speaker Pyle: Is there any other business at this time, gentlemen?

Dr. Dutchess: To revert to the question that I asked a minute ago, I have just been informed that over the radio Dr. Cabot has been broadcasting the fact that they are accepting pay patients at Ann Arbor. I wish to offer a resolution that the Council consider what means may be

taken to curb the acceptance of pay patients at the University Hospital.

Dr. Andrews: I second that.

. . . The motion was carried. . . .

Speaker Pyle: That will be referred to the Committee on Miscellaneous Business. Is there any further business?

. . . The meeting adjourned at twelve o'clock. . . .

TUESDAY AFTERNOON SESSION

SEPTEMBER 17, 1929

The meeting convened at two-forty o'clock, Speaker Pyle presiding.

Speaker Pyle: The Secretary will call the roll.

Secretary Warnshuis: I move you that the slips I hold in my hand represent the second roll call of the House of Delegates.

Dr. Gorsline: I second the motion.

. . . The motion was carried. . . .

Speaker Pyle: We now come to the report of Reference Committees. We will ask for a report from the Committee on the Report of Officers.

Dr. Andrews: The committee begs your indulgence for the short time allowed to review the papers, and wishes to touch on the salient points. If there are any corrections, your committee begs to be informed upon them.

Touching upon the President's address. Taking the first subject, that of lay education, the committee recommends that the Committee on Legislation and Public Policy be requested to review the suggestions on lay education as outlined by the President's paper and act in accordance.

I move this be adopted.

Dr. C. N. Bottum (Marquette): I second that motion.

. . . The motion was carried. . . .

Dr. Andrews: The next subject was taxation without representation. The committee recommends that the House of Delegates wait until the next reapportionment of the House of Delegates of the American Medical Association before recommending that two delegates be appointed from Wayne County.

I move this be adopted.

. . . The motion was seconded. . . .

Dr. Hirschman: There is no occasion there for any recommendation. It is clearly out of order for me or for you or for the Secretary to recommend to this Society, officially, how many delegates should be appointed from any county. It is merely a suggestion to the delegates, as coming from one man to another. But officially that should not be recognized.

I mean by that that we cannot recognize officially the number of delegates which come from any county or any group. I say as a matter of justice a large group should be represented. In other words, there is no definite apportionment of so many to Wayne or Kent, but I think there is really no official action that can be taken on that recommendation. That is for the delegates to decide. There is no objection to the report.

Dr. Andrews: The Committee recommends that the House of Delegates wait until the next reapportionment of the House of Delegates of the American Medical Association before recommending that two delegates be appointed from Wayne County. That is what I moved.

Dr. Biddle: I move that that portion of the report be eliminated.

Dr. McClintic: I second that motion.

. . . The motion was carried. . . .

Dr. Andrews: Secretaryship. The committee passes this subject without recommendation.

President-elect. The committee recommends that the office of President-elect be created and the constitution and by-laws be so amended.

I move the adoption of that section.

Dr. Bottum: I second the motion.

Speaker Pyle: Possibly that is not in order. If you move that a committee be appointed to revise the constitution it would be more in order.

Dr. Andrews: I was merely moving that the recommendation be adopted.

Ex-presidents. The committee recommends that a consulting board of Ex-presidents be created and a resolution to that effect be adopted.

Dr. Bottum: I second the motion.

Speaker Pyle: These are recommendations and should be put in the form of a motion so that the meeting will be clear on the matter.

Dr. Andrews: The committee recommends that a consulting board of Ex-presidents be created and that a resolution be adopted to create that board.

Dr. Hirschman touched upon these points in his paper. He recommended a board of consulting Ex-presidents be created and that a resolution be adopted to create that board.

Dr. Moll: I think it would be a very good idea to get the opinion of all the members of this House of Delegates on

that. That discussion would act as a guide to the committee. If they see how the members at large feel about this matter, it will be far easier for them to come to a conclusion that will meet with the approval of all. I take pleasure in seconding that motion.

Speaker Pyle: Is there any discussion of that motion?

Dr. Henry R. Carstens (Wayne): Wouldn't it be proper to refer it to the committee on Revision of Constitution and By-Laws, if that is authorized? There are quite a few things to discuss, such as whether this is a final formal advisory board, or if it is only for a certain period of years. They will be definitely members of the governing bodies. That could be taken up by the committee, if that is authorized, and whenever it is appointed.

Speaker Pyle: We, as a House of Delegates, cannot add delegates to this county and we cannot create a board. We must revise our constitution and by-laws. I feel the motion should be such that we can refer these recommendations to that committee if I am authorized to appoint it in order that it may take up that matter.

Dr. B. R. Corbus (Grand Rapids): That suggestion to have a committee of Ex-presidents has a certain sentimental appeal. But, as a practical thing I am inclined to question it. Certainly, we want to feel at liberty to call on the Ex-presidents and we will find it necessary, as a Council, to call on the Ex-presidents frequently. However, I do not feel that we are going to get very much farther cluttering things up with a Committee of Ex-presidents whom we have the privilege of calling upon as individuals at any time.

It would seem to me that the way to dispose of this is to put it up to the committee that has to do with the constitution and by-laws and let them consider it very carefully as to whether we want to add more timber to what we now have.

Dr. Hirschman: May I explain the purpose of that? As I mentioned in my address, when a man has been the president of a society he has been in intimate contact with all the activities of it and he is possessed of a certain amount of knowledge and experience which really should not be lost to the society. I am sorry that I have to speak of this as I am the next impending Ex-president.

However, I am thinking of men like Burr, who have been doing great things and who are still willing to serve. It isn't my idea to encumber the Society, but I think, in matters of ethics, finance, legislation and matters where you want all the attention of men who have been intimately associated with the activities of the Society for a long time, perhaps their opinions, mentally, morally, physically, or financially, may be of some value to the Society merely as a sort of reservoir to draw on in case of necessity.

I thought they really should be tied up in some way with the activities of the Society. I was agreeably surprised when Dr. McCormack mentioned that they have such an organization in Kentucky. He told me of that. I hadn't heard of it. They do use those men for the same purpose for which it is our intention to use them.

Dr. R. C. Stone (Battle Creek): I rise to emphasize what Dr. Corbus has already said to you. During the past eight or nine years, since I have been a member of the Council, invariably the past presidents, and numerous other members of the Society, whose knowledge of the affairs of the Society have been valuable, have been consulted.

I think, along with Dr. Corbus, that that is a sentimental idea, the practicability of which is somewhat questioned by me. I know the personnel of the Council will always feel at liberty to take advantage of every opportunity to consult men who have definite knowledge upon any definite subject concerning the activities of the Society.

Dr. Brook: Is there a motion before the house?

Speaker Pyle: Yes, the way I understand the motion it is a recommendation to the committee that is to be appointed later.

Dr. Stanley W. Insley (Wayne): May I make a motion that we adopt that committee and let this go through?

Speaker Pyle: The way the chair understands this it is a recommendation to a committee that such a group of Ex-presidents be created.

Dr. Andrews: We recommend that a resolution be adopted to create that board.

Secretary: May I clear up the Speaker on that, the matter of the committee to revise the constitution and by-laws has been acted upon. Therefore, you are not going to stray by giving it to this committee.

Dr. Andrews: The recommendation, then, is that the committee recommends that a consulting board of Ex-presidents be created and a resolution be adopted to create the board, and that resolution be

sent to the committee on Revision of the Constitution and By-Laws, if such a committee is appointed.

Dr. Brook: We are now up to the portion that I wished to speak on. I would like to move that this portion of the report of the committee be referred to the Committee on Revision of Constitution and By-Laws.

I would ask now if that motion is in order.

Speaker Pyle: Dr. Andrews has made a motion. If you wish to amend it, Dr. Brook, you can.

Dr. Brook: It cannot be done because this motion is in contradiction to his motion.

Dr. Andrews: If the chair so desires I will withdraw the motion and request that Dr. Brook place his motion before the house.

Speaker Pyle: Then Dr. Brook's motion is that this portion of the committee report be referred to the Committee on Revision of the Constitution and By-Laws, if such a committee is appointed.

Dr. Cassidy: I second the motion.

. . . The motion was carried. . . .

Dr. Andrews: Vice Presidents. The committee recommends that Vice Presidents be actively engaged, with the Councillors in sectional matters and the committee also recommends that the state be divided into four sections and the Vice Presidents be sectionally chosen.

I move that that recommendation be adopted.

Dr. McClintic: I second the motion.

Speaker Pyle: The chair will entertain discussion at this time.

Dr. McClintic: I would move that this portion of the report be referred to the prospective committee on Constitution and By-Laws.

Dr. Basil L. Connelly (Wayne): Wouldn't it be a wise plan to call for the report of this other committee and find out what that committee has done and then have the report of this committee? We will then not have to refer these things to a committee that is not yet appointed or authorized.

I move that we hear the report of the committee regarding the appointment of a committee for the revision of the Constitution and By-Laws.

. . . The motion was seconded and carried. . . .

Dr. Andrews: We have reviewed this matter and have attempted to make these recommendations. Right at the present time I am at a loss to know whether I had better go on with these or not. I do not know what they do want. I am somewhat at sea.

Dr. A. W. Hornbogen (Marquette): I think we are acting entirely upon the recommendations of our President. These recommendations are to be placed before us as the recommendations of the committee. It is up to the house to accept or turn them down. It is immaterial to the committee which you do. It is up to you people to do it. We are acting on the recommendation of the President.

Dr. Andrews: I will continue with the report.

In touching upon the Speaker's address the committee recommends that the subject of lay education, which has been touched upon in the President's address, be followed as outlined. If you will remember, the committee recommended that this be turned over to the Committee on Legislation and Public Policy, they being requested to review the suggestions on lay education as outlined by the President's paper and act accordingly.

I move that this recommendation be adopted.

Dr. Hornbogen: I second the motion.

. . . The motion was carried. . . .

Dr. Andrews: The committee recommends that the Constitution and By-Laws be revised and that a committee of five be appointed by the Speaker.

I move that recommendation be adopted.

Speaker Pyle: That is in conflict with another resolution.

Dr. Brook: The other resolution mentioned a committee of three. I want to defend that particular number, three. The larger this committee is, the worse it gets to do the job. The fewer you have with experienced heads, the better the job will be done. I think three should be the number as mentioned.

Speaker Pyle: That motion was carried awhile ago. However, the gentleman has a right to reconsider that motion or make a motion to take that one's place.

Dr. Andrews: I will withdraw mine.

The committee recognizes the suggestion for President-elect in the Speaker's paper and has made provision for same.

The recommendation is that the five recommendations of the Legislative Commission be adopted as read.

I move that that be done.

Dr. Hornbogen: I second the motion.

Dr. Andrews: The five recommendations that were contained in the report of the Legislative Commission are as follows:

1. That the Legislative Commission's report be accepted and the Commission be discharged.

2. That the President appoint a new Legislative Committee by and with the advice of the Council, with the State Secretary as ex-officio head of the committee.

3. That the Legislative Committee be instructed to conduct a lay educational campaign and comply with the provisions of our by-laws.

4. That the Legislative Committee be instructed to attempt to secure at least two representatives of the profession in the senate and the house.

5. That the Council request the Joint Committee on Public Education to arrange a series of talks related to medical legislation and impart them through their channels of public contact.

Speaker Pyle: You have heard the motion and the different points.

Dr. McClintic: I merely want to raise one question on one of the recommendations. It occurs to me that we shouldn't tie the Speaker's hands in appointing the chairman of this committee. It says that the Secretary shall be ex-officio head of the committee. Something might happen that Dr. Warnshuis might not be able to be the chairman of this committee. It seems to me that it should be left so that if the Speaker so desires the Secretary may be made chairman ex-officio. It seems to me that that restriction should not be imposed.

I move that that portion of the recommendation be stricken out.

. . . The motion was seconded and carried. . . .

Speaker Pyle: Now we will vote on the resolution to the effect that these points as a whole, as amended by Dr. McClintic, be adopted. Is there any discussion?

. . . The amended motion was carried. . . .

Dr. Andrews: The Industrial Committee report. The committee recommends that the report of the Industrial Committee be accepted and the resolutions be adopted as printed, the same committee being retained.

The Committee on Medical History. The committee recommends that a vote of thanks be given Dr. Burr and also requests that all possible aid be given him.

I move that that recommendation be adopted.

Dr. H. B. Garner (Wayne): I second the motion.

. . . The motion was carried. . . .

Dr. Burr: I am entirely out of order in speaking here, but may the balance of the committee be included in that resolution?

Speaker Pyle: I think the chair will let that go without a vote that the whole committee might be included.

Dr. Andrews: I move that the report of this committee be accepted and the committee be discharged.

Dr. Hornbogen: I second the motion.

. . . The motion was carried. . . .

Speaker Pyle: We will now listen to the report of the Committee on Miscellaneous Business. Dr. Shaw, Lansing.

Dr. Milton Shaw (Lansing): Your Committee on Miscellaneous Business makes the following report:

Resolution by Dr. Moll, reading as follows:

"Whereas, The American Medical Association and the American Bar Association have under consideration a reform in law and judicial procedure that will eliminate the present methods of obtaining and introducing medical expert testimony, therefore be it

"Resolved, That our President be instructed to appoint a special committee of five to confer with a similar committee of the Michigan Bar Association for the purpose of securing the introduction in the next session of our Legislature the specific recommendations that emanate from the National Conference and thereby early accomplish this reform in our Michigan courts."

Your committee recommends the adoption of the resolution, and I move its adoption.

Dr. A. J. MacKenzie (Port Huron): I second the motion.

Dr. Cassidy: Who is going to do the selecting of the various members, who is going to qualify as an expert, and how is he going to do it? That is the stumbling block there. Who is going to pass on the men, the names that you are going to give to the law makers, or the judicial people, as to the qualifications of that individual as an expert in the courts?

Secretary: May I answer Dr. Cassidy? This resolution is in conformity with national legislation. The American Bar Association has appointed a committee on revision of judicial practice in the admission

of expert testimony in any trial. At the request of the American Bar Association the American Medical Association also appointed a national committee. These two national committees are appointing state committees that study and investigate the state laws and procedures in expert testimony in court procedure.

The intent of this motion is to conform and join in the work of the National Bar Association and the American Medical Association so that there will be some type of uniform legislation made by the Legislatures of the country which will guide the courts in the admission of expert testimony and be rules of practice.

That is as far as that goes. The State Medical Society, the American Medical Association, and the Bar Association are not going to say whether Dr. Cassidy or Dr. Pyle, or any other doctor is capable of being expert witnesses, but they are going to specify the qualifications, in general, then if you want to become an expert witness they must be met or you cannot be an expert witness. That is the idea of the resolution.

Speaker Pyle: Is there any further discussion?

. . . The motion was carried. . . .

Dr. Shaw: The second resolution is that of Dr. McCutcheon as follows:

"Whereas, The American Medical Association will hold its 1930 Annual Session in the city of Detroit, and

"Whereas, The profession of Michigan is desirous of participating in the honor of being hosts to the profession of the nation, therefore be it

"Resolved, That our five delegates, our President and the Chairman of the Council be constituted as an Advisory Committee to the Detroit Local Committee on Arrangements."

Your committee recommends the adoption of that, and I move its adoption.

Dr. Cassidy: I second the motion.

. . . The motion was carried. . . .

Dr. Shaw: The third resolution is that of Dr. Biddle, which is as follows:

"Whereas, The Board of Trustees of the American Medical Association has been authorized to develop plans for a new headquarters building and to formulate a financial program that will enable our National Association to erect such a building of monumental type, therefore be it

"Resolved, That the Council of the Michigan State Medical Society be instructed to appropriate from our reserve funds a reasonable sum and tender the same to the trustees of the American Medical Association as Michigan's contribution to the historical and memorial portion of the new monumental building."

Your committee, therefore, recommends that the Council be instructed to appropriate a reasonable sum for this purpose, and I move the adoption of the report.

Dr. John Wessinger (Washtenaw): I second the motion.

Speaker Pyle: I have just been asked what a reasonable amount is.

Dr. Shaw: That is left to the discretion of the Council.

Dr. McClintic: I feel that we should have a little more information on this as to what this memorial is to cost and as to how it is to be financed. Are the constituent State Societies going to build the memorial? If they are, it means that we will have to come in for a proportionate share. Or, are they going to build from another source? I feel we should have some idea as to what is meant by a reasonable sum. That is entirely too indefinite.

Dr. Biddle: I would call upon Dr. Warnshuis to speak on that and inform the House of Delegates as to the purpose of this sum of money to be raised, and so forth.

Secretary: You have read the report of the trustees of the American Medical Association, rendered at the Portland meeting this last July. That board has recommended to the profession of the country the need of an enlargement of headquarters buildings in Chicago. There has been a considerable amount of sentiment regarding that building, that has been expressed by various state organizations.

At the present time we have a building which they feel is below the dignity of the profession of medicine. You will also recall that the American College of Surgeons has a very wonderful and remarkably beautiful building.

The ground has been purchased for erecting an addition to our present headquarters in Chicago. The idea is to make this somewhat of a memorial type so that it will stand for all time, as an emblem of the American medical profession.

The American Medical Association realizes that this building is going to cost several million dollars. They have made provision for the collection of some of that amount. It is the intent, I believe, of the trustees of the American Medical Associa-

tion to assume the obligation of the entire cost of that building, but the sugestion was made at Portland, and is being tendered to the various State Societies, that they would like to participate in doing something, possibly, in the way of a window, maybe, or a chandelier, or a picture of some sort probably of our leading men in the profession in Michigan, maybe a Council table as a contribution to that memorial building, so that the members of Michigan, as well as those of North Carolina, New York, or California, will have a little more personal interest in that building and so that there will be a little sentiment connected with it.

I do not take it that it is contemplated to contribute $1,000, $5,000 or $25,000. I imagine that the Council, conserving, as it has always done, the finances of the Society, will set a reasonable amount and yet one that will be commensurate with the dignity of the profession of Michigan. They might wish to give them a water pitcher. (Laughter). But, anyway, it is something along that line.

Dr. Biddle: I would like to hear from Dr. Hornbogen.

Dr. Hornbogen: Dr. Warnshuis has covered that entirely, that we need an enlargement of the space in order to handle all the different lines that we are following in the city of Chicago. We need a much larger building for our headquarters office than we have at the present time.

The plan of the trustees is to build a building that will be not for this year or next year, but one that will be for a good many years to come. As I understand it from the Secretary, and also from the Editor, our space is altogether too inadequate. The idea was conceived to build it high enough and big enough to house the entire offices of the American Medical Association and at the same time be emblematic of the American Medical Association.

I wish this House of Delegates would take proper action upon this motion.

. . . The motion was carried. . . .

Dr. Shaw: The next resolution is that offered by Dr. Brook:

"Whereas, Some five years have elapsed since our Constitution and By-Laws have been revised, and

"Whereas, Some obsolete provisions therefore exist in our Constitution and By-Laws, while other provisions to conform to our organizational activities are a necessity, therefore be it

"Resolved, That the speaker be authorized to appoint a special committee of three who shall redraft our present Constitution and By-Laws and present their report at the second session of the next annual meeting of this House of Delegates and that the consideration of their report be a special order of business of that session and further, be it

"Resolved, That this resolution be considered as a special notice of intended revision and that the committee will cause their revised draft to be published in the Journal one month before the 1930 annual meeting."

I move the adoption of that resolution.

. . . The motion was seconded and carried. . . .

Dr. Shaw: The next is the resolution by Dr. Dutchess inviting inquiry relative to acceptance of pay patients at the University of Michigan Hospital, contrary to the recommendations of the State Society Special Committee on Clinics and Hospitals.

The committee, after discussing this matter with the Council, recommends that the spokesman for the Council be asked to make a statement giving the Council's view of the existing situation.

I move the adoption of that report.

Dr. Wessinger: I second the motion.

Speaker Pyle: Is there anyone from the Council here to discuss this before us?

Dr. Shaw: The motion is that the committee, after discussing this matter with the Council, recommends that the spokesman for the Council be asked to make a statement giving the Council's view of the existing situation.

. . . The motion was carried. . . .

Dr. Shaw: I move the adoption of the report as a whole.

Dr. Gorsline: I second the motion.

. . . The motion was carried. . . .

Speaker Pyle: If the house so wishes we might listen to the Chairman of the Council, Dr. Stone.

Dr. Stone: Mr. Speaker, Dr. Bruce will act as spokesman for the Council in answering this question.

Dr. J. D. Bruce (Ann Arbor): Mr. Speaker and Gentlemen: On the presentation of the report last year Dr. Smith came to see me at the University with reference to discussing the proper method of bringing the matter before the University authorities, that is, the matter of findings and the recommendations of the committee.

We took the matter up with Dr. Sawyer

at that time, the senior member of the board, and the medical member of the board, and it was his opinion that due to the fact that unrest obtained at that time in administrative circles in Ann Arbor, particularly with reference to the position of the President of the University, because of certain views that he held, it would be unwise to bring the matter of this report up for a decision before the board at that time.

Since that time President Little has resigned. We will soon, I hope, have a new administration. It is Dr. Sawyer's wish to bring the matter of the recommendation of this committee before the Board of Regents at the earliest possible opportunity after the new administration is in.

My own personal opinion is that this has been wisely dealt with. The Society, as a whole, has been patient with reference to this matter. I think a little further exercise of patience will eventuate in some worth-while consideration of the opinions expressed in this committee and supported by this House.

I thank you. (Applause).

Speaker Pyle: We will now listen to Dr. Whittaker of Detroit.

Dr. A. H. Whittaker (Wayne): I would like to mention that during the last few months we have made a rather careful study of the situation that Dr. Bruce mentioned. We wanted to make a rather full report on it. However, I had a conversation with Dr. Bruce and from what he said it might be just as well not to bring up the report at all.

I would like to bring to the attention of the delegates today that the ones who have been working on the situation expect to keep it in mind and as soon as there is a change in administration, if there is no action taken on the subject, we expect to bring it to the attention of the officers of the Society.

I think some change will come about before the next meeting of the House of Delegates of the Michigan Medical Society.

Speaker Pyle: Is there any further discussion?

Dr. D. J. Leithauser (Wayne): I wonder if it wouldn't be possible to have them discontinue the radio talks from Ann Arbor stating that they are now taking care of paid cases and that they admit everybody.

Speaker Pyle: That might be better discussed under the head of miscellaneous business. I will entertain a motion like that after the regular order.

Dr. Leithauser: I thought it might be answered now as long as it is under discussion. I do not see why we shouldn't have an answer on it now.

Speaker Pyle: Does anyone wish to discuss that?

Dr. Carstens: I believe the very able committee of Dr. Smith's last year was continued and they have maintained contact with the situation. I wonder if it wouldn't be well to continue the committee, or re-appoint them if necessary, directing Dr. Smith to continue maintaining contact with the situation and have him make a further report next year.

The recommendation of Dr. Leithauser might be appropriately referred to that committee for investigation and consideration. That committee was a very able one and it went into this matter very thoroughly. They are working on it.

Speaker Pyle: Let us put a definite question before the house, a motion of some kind, and then we will have a regular discussion. Does anyone wish to make a motion regarding this point?

Dr. Leithauser: I wish to make a motion that their radio talks from the University on this subject be discontinued until the new administration comes in.

Speaker Pyle: The House of Delegates cannot stop radio talks. The chair feels it is in order that some committee see the people responsible for the offence, if it is one, and make certain recommendations.

Dr. Bruce: May I say a word or two on that?

I do not think it is fully understood—the present status of this question. Dr. Smith and his committee were continued last year. I wish to correct that impression, they have been doing something. They have been in touch with the situation. It is Dr. Smith's feeling that—or wish, I might say—you see I have discussed the matter with him—that the matter be left in the state in which it is now and he is willing and will report as soon as what they consider appropriate action can be taken.

With reference to the suggestion that was made a moment ago: I really think we would make ourselves rather ridiculous if we brought this question up at this time. We know that that question has been mentioned only on one occasion, the matter of the paid patients at the University Hospital. That is not in accord with the spirit

of the resolution and will be dealt with as a whole.

My feeling is that within the next sixty days some action will be taken. I do not know whether it will be favorable to the resolution or not, I have no means of knowing. I do know this, that Dr. Sawyer proposes to bring the whole matter before the Board of Regents and some kind of action will be taken. What that action will be I am not prepared to say.

However, I do feel that it isn't going to help the situation at all for us to make any further moves at this time because, with the gentlemen who have spoken, I think we will all agree that the matter is in good hands when it is in the hands of the very capable committee that has charge of it at the present time.

Speaker Pyle: The member could make a motion that you recommend certain things to the committee. A motion of that kind would be in order if any delegate feels that is necessary. Is there any further discussion on this subject?

Dr. L. O. Geib (Wayne): I make a motion that the House of Delegates disapprove the action of the University of Michigan Hospital in soliciting paid patients for the hospital over the radio.

. . . The motion was seconded. . . .

Speaker Pyle: Is there any discussion?

. . . The result of the vote was in doubt. . . .

The result of a rising vote was as follows:

For the motion	21
Opposed	14

Speaker Pyle: The motion is carried.

Speaker Pyle: We will now listen to the report of the committee on the report of the Council.

Dr. McClintic: Your committee begs leave to recommend:

First: That the House of Delegates commend the sincere, conscientious, efficient and intelligent manner in which the Council has conducted the affairs of the Society during the past year.

Second: The committee begs leave to call the attention of the House of Delegates to the sound financial condition of the Society as indicated in the report of the Council.

Third: The House of Delegates should commend the Council for the advancement made in the work of post-graduate education and would suggest that the House of Delegates at this time give consideration to the plan of having the Council lend its aid to the further realization of the aims of the Michigan State Medical Society in the ultimate establishment of an institution for the purpose of clinical research and post-graduate medical teaching.

That is the recommendation of the committee and we beg to put it before the house. We would like to move that the House of Delegates do, at this time, take up this matter of establishing a post-graduate institution of education.

. . . The motion was seconded and carried. . . .

Dr. McClintic: The committee recommends the election to Honorary Membership the following:

Dr. R. N. Eccles, Blissfield, Lenawee County.

Dr. A. M. Hume, Owosso, Shiawassee County.

Dr. Van Horn, Otsego.

Dr. C. B. Wasson, Bellevue, Eaton County.

Dr. H. B. Robinson, Manistee, Manistee County.

I move the election of these physicians to Honorary Membership in the Michigan State Medical Society.

Dr. Stone: It seems to me that the name of Dr. W. L. Godfrey of Battle Creek should be included.

Secretary Warnshuis: That was written on the side of the report. It probably was merely overlooked in the reading.

. . . The motion was seconded and was carried. . . .

Dr. McClintic: The committee further recommends that the House of Delegates give special consideration to the conditions referred to in Dr. West's report, which is incorporated in the report of the Council concerning fewer and more compact organizations as opposed to the multiplicity of societies which divide and subdivide our official societies into sub-groups to the detriment of the parent organizations and that a resolution, as suggested by the Council, be adopted and that such steps as are necessary be taken to carry the resolution into effect.

The Council recommendation was that a proper resolution be adopted expressing the desirability of the County Societies taking such action relating to the practice of medicine and public health welfare in the counties.

I move the adoption of this resolution.

. . . The motion was seconded and carried. . . .

Dr. Leithauser: Does that eliminate all the Societies?

Dr. McClintic: The Council is recommending that the resolution should be adopted so that it will bring the County Societies into leadership in all the problems relating to medicine and public health welfare in the counties.

Next is that measures be taken to make the standards recommended by the American Medical Association, the standards for hospitals as regards buildings, equipment, service, staff meetings and clinical conferences instead of having two standards as at present.

We might explain that by saying that at present there are two committees in existence which presumably standardize hospitals. One is that of the American Medical Association, in association with the American Medical Colleges, and there is that of the American College of Physicians and Surgeons. At present hospitals have to conform to both of those standards. We want to have the approval of the American Medical Association so that there will be only one standard. There is now one condition which the College of Surgeons have to approve.

In other words, the medical schools only recognize work done in a hospital approved by the American Medical Association. On the other hand, the state boards only recognize an interneship served in a hospital approved by the American College of Surgeons. The purpose of the resolution is that some measure should be taken whereby this may be corrected. Either we want the American Medical Association to say what constitutes a proper hospital for an interne, or we want the College of Surgeons to say so.

Dr. Brook: Which does the committee recommend?

Mr. McClintic: The American Medical Association.

Speaker Pyle: What process would you suggest to the assembly to go about this in order to make it effective? Do you put this in the form of a resolution?

Secretary: That is for your officers and Council to carry out.

Dr. McClintic: Let the House of Delegates decide.

Dr. Cassidy: How are the House of Delegates going to have anything to do with the College of Surgeons? The original standardization of hospitals was done by the American College of Surgeons and not by the American Medical Association. Are you going to push them back now and say that the American Medical Association should step in? There is a difference in the report of each institution. The American College of Surgeons report embodies considerably more than the American Medical Association report.

Dr. Leithauser: Is there a fundamental difference?

Dr. Cassidy: Maybe Dr. McClintic can tell us.

Dr. McClintic: The matter came up in this report. I do not think it is a small problem. Dr. Bruce can probably enlighten us on this. I do not think it is a small problem at all to get the two standards in conformity. I know perfectly well that the graduate medical man serving an interneship has a lot of trouble. He may go into a hospital that is approved by the surgeons and the state board will accept him, but his college will not graduate him even though he has served that interneship because it happens that that hospital is not approved by the American Medical Association Committee on Hospitals. It is a question to be ironed out and we should take steps to iron out the difference.

Dr. Hornbogen: I think if you will take the trouble to read the report of a number of hospitals that are credited under the American Medical Association in the United States you will find that almost every institution in the United States is included as recommended by the American Medical Association with the exception of a very few minor institutions that never expect to have an interne.

I consider that the rating given by the American College of Surgeons is much more stringent than that given by the American Medical Association or by the American Hospital Association. I cannot see why any state board of registration of medicine should not accept the interneship in any hospital under the rating of the American College of Surgeons. I consider that their regulations are much more stringent than those of the American Medical Association. The American Medical Association has almost every hospital in the country that can really be called a hospital.

Speaker Pyle: There is no motion as yet before the house, gentlemen.

Dr. A. D. Allen (Bay City): Out of all the hospitals in the United States that I have had the occasion to look this up in, there are about 600 hospitals that are rec-

ognized by the American Medical Association as fit for teaching. They require the things the American Medical Association requires.

The thing that brought this up for a discussion in the committee meeting was the number of meetings that you have to have in a hospital to comply with the two standardizations. That is the question that we wish to bring before the House. They have one standard rather than two standards. We wish to bring that before you at this time.

Dr. McClintic: I think this should be taken under consideration and there should be a report on it to the next House of Delegates.

I would move that that recommendation be thus accepted.

. . . The motion was seconded and carried. . . .

Dr. McClintic: The Michigan State Medical Society is to be congratulated upon the high type of executives and business men who compose its Council, to say nothing of their high professional and ethical standards.

The affairs of the Society are in safe and sane hands and the committee recommends the adoption of the report of the Council as a whole and asks that special consideration be given by the House of Delegates to the matters above suggested in this report.

Speaker Pyle: Is there any other business, or are there any committee reports?

Secretary: May I call the attention of the delegates from the Thirteenth and Fourteenth Districts to the provision in our by-laws for the nominations of Councillors whose terms have expired? Nominations are made by the delegates from these districts and are tendered by them to the House at the election this evening. Consequently the delegates from those two districts should get together sometime this afternoon, or before the meeting tonight, and tender their nominations at the proper time this evening.

A request has come to the House of Delegates from a group of our members from South Haven. They are, and have been for the past six months, confronted with a rather serious problem, a problem that sooner or later, as has been intimated by the Legislative Commission, is going to come before every hospital in the country, that is the admission of cultists to take care of patients in that hospital.

The profession at South Haven is in a turmoil with their Board of Supervisors and City Council regarding the admission of the patients of cultists. Dr. Penoyer representing the profession of South Haven, has come before this House asking the privilege of the floor in order that he may state to you the problem with which they are contending and to secure your advice to guide them in their deliberations and negotiations with their Supervisors and Council.

Dr. Andrews: I move you that Dr. Penoyer be given the privilege to speak before the House.

. . . The motion was seconded and carried. . . .

Speaker Pyle: We will listen to Dr. Penoyer.

Dr. Penoyer: Mr. Speaker and House of Delegates: This matter began about six months ago. At that time I had been recently appointed to our local Hospital Board. I am now serving on that board as Vice President. However, I am here merely as a physician and not as a member of that board.

I was astonished first to know that the osteopath there was asking to bring his cases to that institution. Prior to that time I didn't know what an osteopath was. I wrote a letter to Dr. Warnhuis. He very clearly and concisely stated what an osteopath was. However, as soon as I showed his letter down there in our city I was informed that Dr. Warnhuis didn't know what he was talking about. (Laughter). Therefore, I have a lot of matter that I am going to try to hurry over so I can give you the gist of the matter.

Subsequent to that I wrote to Dr. Connor, the Secretary of the State Board of Registration. I merely asked Dr. Connor if this man was registered there. I knew he wasn't. I got a reply in the negative, that he was not. However, he sent me a lot of copies of laws. I couldn't, and no one else seemed to be able to make much of those.

Apparently, the law is ambiguous or lacking. Following that I wrote to their own registrar, to their own board. At first they weren't even courteous enough to answer me on their own stationery, but merely added a postscript to my letter. He negatived everything I asked him. Therefore, I asked him to be more specific. Then he favored me with his own stationery. He said that he was enclosing a pamphlet of their law and asked me to kindly return it because it was the only one that he had.

That says that there has been a court

decision allowing osteopaths to practice all forms of surgery. There has never been any question about osteopaths having a privilege of practicing obstetrics or giving anesthetics.

I asked a question on that and I wanted to know what he would do. I am informed, however, that they can do all of that and that they can even do surgery. I have seen some circumcisions and things like that.

Following that I communicated with Dr. Warnshuis. He advised me to communicate with the American Medical Association and said I should come down to this meeting.

The American Medical Association really sent me a very wonderful report. I thought, when I read that, that I had everything licked right there. Our city attorney, who hadn't entered all of this, read the American Medical Association report and informed me that they were all wet.

Our situation there, as I see it, is: Is an osteopath allowed, according to the laws of the state of Michigan, to practice obstetrics, or to give medicine of any type regardless of what method may be given? I think our local problem there is: Can a hospital, or a city hospital—if I make myself clear—select its own staff, or have they no privilege of selecting their staff? That is really our problem, the selecting of our staff.

Yesterday, prior to coming here, I again consulted with the city attorney. He told me that this House of Delegates had nothing to do with that fight, that it was our own problem down there, that this State Society, or these groups of men here have nothing whatsoever to do and they cannot come down there and enter into this. That is why I wanted to make myself clear that I am here as a physician and not as a member of that staff. As a member of that staff, of course, I have to take the opinion of our city attorney. Therefore, I am not here in any way related to our Hospital Board, but merely as a physician.

All of the physicians there, of which there are four, are of the same opinion as I. We have said that we want to put it, as a group, before the Hospital Board, which consists of a group of laymen. They have asked us whether our fight was against the osteopaths as individuals, or as a cult, and they have also asked us what right we had to tell our patients who may or may not come into that hospital and be cared for by this person or that person.

We have told them that if it wasn't our legal right it was at least our moral obligation to protect our community from people coming into that institution and have our city put a stamp of approval on those cult people by admitting them into the institution. They have laughed at us, saying that we were assuming an awful lot when we assumed the moral responsibility of a community as a whole because we had not in any way been delegated to that responsibility.

Dr. George Hafford (Calhoun): Is yours a municipal hospital?

Dr. Penoyer: Yes.

Speaker Pyle: The Secretary mentioned that they had trouble of this kind in Jackson. Is that right, Dr. Riley? How did you handle it?

Dr. Philip Riley (Jackson): We had some patients in the hospital where the people were Faith Healers. They wanted to bring the chiropractor in and they asked me if it was all right. I said "No." They went to the superintendent of the hospital and she said "No." Then they went down to the City Commissioner, I guess, to get action and allow them in. In the meantime the patient died. (Laughter).

We had another situation. We had a man in town who said he had gotten an M. D. from some place in Georgia. He got this degree about 1903 or 1904. He took up osteopathy and worked on that. Then he decided it wasn't very profitable, so he tried for a reciprocity. The board denied him, but I guess he got it through the court. Now he practices osteopathy and surgery and anything that he cares to in the city hospital, but they do not allow him in the Sisters' Hospital.

Dr. Hafford: I don't know whether you would be interested in this or not. We have a hospital that is about the same size as his, but we are on the competitive list of the College of Surgeons. The osteopaths and chiropractors have been sort of forcing it with some of the friends of the cults, but when they applied they were told that they had to have a standing and we couldn't let them in because we would lose our standing in the College of Surgeons. In other words, we would not be a medical hospital if they were allowed to practice in there. We got rid of those. So far none of the members of the profession are on the Hospital Board. The Hos-

pital Board is a lay board. We have carried on all right so far.

Another thing came up the other day. We have a couple of colored physicians who came in recently and who wanted to bring patients to the hospital. They were informed that they could only bring them in when they were under the supervision of one of the regular staff of the hospital.

Speaker Pyle: If it is not out of order and if the members have no objection, the chair would like to hear from Dr. Connor of the State Board of Registration, if he is willing to discuss this.

Dr. Connor: I haven't very much to say. I will say this, however, that as far as the Michigan Board is concerned we have all the hospitals on the list of the American Medical Association except one, and that is purely for colored people and colored doctors. I took that up with Caldwell and he thought it was a good idea to give these colored fellows a chance for interne service. We do not have much trouble.

For instance, in a small hospital like some of those mentioned, all we want is a man to get reasonable training so that when he gets through he will make a reasonably good doctor. That was one reason why the board some years ago instituted a service so that the man will not be limited to small service only for the first year. If he wants to be a specialist it is a good idea for him to spend more than a year in the hospital.

Speaker Pyle: Does anyone wish to discuss this, or have you any way of aiding the doctor from South Haven in his problem? That is what he is here for.

Dr. Hirschman: I would like to have Dr. Kiefer give us something on this.

Dr. Kiefer: I am afraid that I cannot help out the doctor. He asked a few questions in the first place about osteopaths and what they had a right to do.

In Michigan, as far as I know and can find out, they have no right to do that. They do it, but they have no right to practice obstetrics. That has been given as an opinion by the Attorney General.

Under a new law which went into effect about August 28, they have the right to give narcotic drugs. That has been settled. They have not the right to give other drugs as this gentleman said they had a right to give everything. That is as far as the law is concerned and as I understand it, but they do these things just the same.

It seems to me that the solution of that problem rests with the Hospital Board. I do not know who the Hospital Board are, but the Hospital Board will make a rule that no other but doctors of medicine can practice in that hospital and that will settle it. If they do not make such a ruling, then he is going to lose out. That is the way it looks to me.

The other scheme of getting the hospital on the accredited list and then saying that they cannot take them because of the lack of requirements amounts to the same thing. If the hospital will not make a rule excluding those men, I am afraid they cannot do anything else. That is the way it looks to me.

For instance, we have the large municipal hospital in the city. They have certain conditions there, but the governing board of that hospital is a board of governors that is made up of a few doctors of medicine and of laymen. There is then no chance of anyone but an M. D. getting in there. It does seem to me that it is up to the Hospital Board and if Penoyer thinks that the Hospital Board of which he is a member are in favor of letting the men in, I am afraid that he has lost his fight. If he can get them to vote against that, then he has won it.

Dr. Penoyer: All the points that are coming up have been fought through. The Hospital Board are taking their opinions from our city attorney in order to draft resolutions that will hold water. He says that we cannot exclude anybody as long as they are practicing with a license as issued by the state of Michigan. It is our information at this time, as received from the State Board of Registration of Osteopathy that they can practice obstetrics and surgery.

Dr. Kiefer: I would advise you, then, to get an opinion from the Attorney General. I think you will find that he will differ with the city attorney.

Dr. Penoyer: We tried to do that, but cannot get it.

Dr. Kiefer: I will get it for you.

Dr. Whittaker: I might offer a suggestion. Dr. Kelly of the State Board of Registration tells me that he had a conference with the Governor two weeks ago and he hopes and expects to get the cooperation of the Attorney General's office in the prosecution of people doing things they should not do. If he does get that cooperation and each District Attorney throughout the state, who is a Deputy At-

torney General, is on the lookout for people practicing the kind of medicine they should not, the procedure for the doctor would be to pick out a layman friend, pick out a specific case in which the man did a surgical operation which he was not entitled to do, have the man bring a complaint against the osteopath and then turn it over to the Attorney General and it will be prosecuted.

Dr. Garner: As I understand Dr. Kiefer, he remarked that osteopaths have no right to practice surgery or obstetrics. In Highland Park we have a hospital that is run by osteopaths. They do surgery and obstetrics. We also have some doctors in there. I think we can help a lot by cleaning up there. I think we ought to clean our own dooryard and then we can help this man and everybody else, too.

Speaker Pyle: Is there a further discussion?

Dr. Leslie T. Henderson (Wayne): Would it be policy to refer the doctor's complaint to the Legislative Committee who, in connection with the Council could work out some way to thresh out this, taking it up, if necessary, with the American Medical Association? That probably would bear some weight on that community.

I will make a motion to that effect.

The motion is: That the doctor's complaint be referred to the Legislative Committee in connection with the Council of the Michigan State Medical Society and if necessary they take it up with the American Medical Association and see if we cannot put weight on the local authorities in South Haven and make them take notice of what we have to say as a national body, have that coming from the State Society.

. . . The motion was variously seconded. . . .

Dr. Cassidy: I would like to know how much pressure you are going to put on a prosecuting attorney who goes out for election among his people? Where are you going to put your pressure? The trouble is that we always have the cart before the horse. Get your local Societies to wake up and see who the men are who are runing for Prosecuting Attorney. If that fellow won't play with you, then it is up to you to play with somebody else. That is the fundamental thing of the whole proposition. (Applause).

In all of our state legislation we have been hitting at the wrong end of the wire. The County Societies haven't done their duty. If we do not wake up pretty soon, it will be a repetition of what Dr. Penoyer has in his county. You can see that the practice of medicine has been dissipated there and we are fighting their medicine and not their practice most of the time. It is getting worse and worse and it will continue to get worse.

The minute that the Narcotic Division of the United States Government opened up morphine to the osteopath what did it mean? They recognized him as a practitioner of medicine. How are you going to get by with it? How are you going to force it if the United States Government recognizes him so that he can give medicine? How then are you going to say that he cannot? If he pays taxes to the municipal hospital then how are you going to keep him off the staff? He is an expert and has a right to the hospital just as much as you have.

The American College of Surgeons can standardize and give you a rule and regulation as to what you should do but they cannot say anything to him. They have no control over him. He is regulated by the osteopathic or chiropractic board. That is another situation that you have to contend with. That is the situation that is coming into every hamlet and it is also coming into the situation if you have municipal hospitals. You will not keep them out. They have made up their minds to get in and they will get in.

How? They will go down and have men go to Lansing. They will have them buy the Legislatures and they will get by. We sit down and wait until the last minute and then try to kill the thing at that time. That has been the whole trouble with the profession all the way through, we haven't acted at the source. We have tried to stem the current after it has gotten under way. The result is that it has swamped us. Unless we recognize the fact now we will go on being swamped. These fellows are coming year after year.

In the last Legislature they showed more hours of medical study than the regular profession could show. Did anybody come up and dispute that in the newspapers? Very few—I didn't see anything. They said they had something like 500 more hours of study than the regular profession did. Here we have been going before the Legislature and saying that these men have not had a sufficient medical education. Where is the nigger in the woodpile?

You cannot say we have more hours and then have them come up and place their hours before the various Legislative boards. You have to get something concrete and get it soon. It must start in the parent organization in the county. You cannot expect the secretary of the Michigan State Society to rush down and stop all the legislation in the period of a week or ten days of the time in which it is to be brought up. You have to start in the county society and see who the man is who is going to represent you in the state and find out what his attitude toward the medical profession is going to be. Do not wait until the senator gets there and try to find out then. Find out beforehand if he is antagonistic. Then you have things in your own hands. You come in contact with people and you can mold public opinion. But you cannot do it by rushing out at the last minute.

If this is taken into consideration the whole medical question can be controlled if the medical profession will only realize that they have a problem on their hands and that it is going to take a lot of work and money. We have to create a fund in order to fight these things. If the Legislature can be bought then when you are in Rome do as the Romans do.

Speaker Pyle: There is a motion before the House. Let us have the discussion on the motion that was made.

Dr. E. C. Baumgarten (Wayne): I wonder if in Dr. Henderson's motion we are getting right at the proper way to get at this thing? I think the thing is much more serious than we think. If this man in South Haven gets away with it it means a precedent will be set, and that is going to be reported by him to the Osteopathic Association and then the information is going to spread.

Is there any other body which functions in our state Society that could take this matter up? I think this is just as important as our legal defense if not more so. Here is a chance where we ought to be willing to spend a little money to help these fellows out there so that they can get rid of that man.

Secretary: I take it from the intent and purpose of the motion that this question of cult practice in community, municipal and other hospitals in the state was referred to the Legislative Committee carrying this instruction, that they not only enter into the consideration of the situation in South Haven but consider the situation of the state as a whole and that that committee formulate a plan or a policy and collect certain data and evidence, or whatever opinions it requires, that will then be available not only to the men in South Haven but to every hospital community in the state. So in that way they may combat any wildfire spreading of such a movement. That, I take it, is the intent and purpose of the motion.

Dr. Baumgarten: That answers my question. If it implies that they are going to give the fellows some definite aid at the present time and not just a lot of data that the committees will have to report on next year. Can we help them out now, that is the point?

Dr. Henderson: I talked about the South Haven question but I meant the whole thing in general.

Speaker Pyle: State your motion again, doctor.

Dr. Henderson: I move that the doctor's problems and any other problems that have come up in the state of Michigan be referred to the Legislative Committee of the Michigan State Medical Society and the Council and they should take it up, in turn, with the American Medical Association so that it will become a national affair.

. . . The motion was variously seconded. . . .

Dr. Brook: As I understand it from one of the committee reports, the Committee on Miscellaneous Business, I believe the Legislative Commission report has been accepted and the committee has been discharged with the thanks of the House. With the consent of the maker of that motion I would like to make a substitute motion that the matter be referred to the Council and the State Commissioner of Health.

Dr. Henderson: I take it for granted that there will be another Legislative Committee, or Commission, to be appointed and they will take up this affair.

Speaker Pyle: Is there a standing committee?

Secretary: There is a standing committee provided by the by-laws, a Committee on Legislation and Public Policy. The Legislative Commission was only a temporary one.

Speaker Pyle: Is that all right, Dr. Brook?

Dr. Brook: Yes.

Speaker Pyle: Is there any discussion?

Dr. Biddle: Are you instructing the committee to report to the American Medical Association? If they think it wise to do so they will do so. It just refers it to that committee with power to act and act immediately.

Dr. Henderson: That is the purpose of the motion.

Dr. Biddle: They want immediate help. A month may be too late. I do not see any necessity of instructing that committee what to do, but just give them the power to do it.

Dr. Brook: That is the reason I mentioned the Council because they have more authority than the Legislative Committee would have.

Speaker Pyle: The Council is mentioned in the motion.

Dr. Manwaring (Flint): We have come through this. This man from South Haven isn't getting the help that he wants. We have a recent court decision covering all of these points. The control of a hospital in the state of Michigan rests absolutely with its board. The doctors, of course, and other people haven't anything to do with it. It has a board of control, the authority of which cannot be delegated to any other body. They determine who shall practice there. They have the right to set such standards as they see fit to insure that the patient shall receive the proper care.

The mere fact that a man pays taxes, is a physician, no matter what kind he is, does not entitle him to practice in any hospital. That doesn't give him any more privileges than if he didn't pay taxes at all. He cannot go down and run one of the city automobiles when he wants to and it does not entitle him to the use of the tools of the city and their facilities just because he pays taxes.

Furthermore, if he feels he has some grievance he cannot withhold his taxes. That is supposed to go to the support of the hospital. Those points have all been settled. In carrying out its policies the Hospital Board has the right to put such restrictions on there as it may see fit as long as they are not arbitrary. That is to say, it cannot through its own whim or any other insufficient reason select certain men who may practice in the hospital. Arbitrary is the word that the court hangs its decision on. You want to learn the definition of that because they are going to ask you. We had a mistake made in our trial because of that.

The court holds that men are entitled, if they are licensed, to practice in the hospital provided they meet the requirements of the board. The board has the right to place restrictions but they must meet the same standards. It doesn't make any difference whether they are osteopaths or other kinds of doctors.

This is an awfully easy thing to control if the Hospital Board will have a staff organization of some kind. They may have an advisory medical board and they may require the examination of these men. They may require that the men practicing in the hospital should pass certain qualifications.

We have a hospital of 320 beds. It is a city hospital. The osteopaths do not practice there. They desired to but they didn't get much encouragement. What kept them out was requiring all staff members having the qualifications laid down by the State Board of Registration. It isn't mentioned in that way at all. We take the requirements that they have and repeat them in our regulations, it is simply that he shall be a graduate of a medical school with a four-year course, and he shall have served one year as an accredited hospital interne and so on. There isn't an osteopath that can meet those requirements.

In order to let in the old doctors who didn't serve an interneship and didn't have the six-year course and so on they simply state as a part of that for the older physicians who were licensed prior to that time that they shall have had, at the time of their being licensed, the requirements laid down by the State Board of Registration in Medicine. That applies to all of them. That lets in any physician who has had the proper training in medicine and it bars all others and does it legally.

The problem at South Haven is to get the Board to do that. The legal points have been well covered. The Supreme Court of the state of Michigan has not covered all of these points but it has covered some of them. This judgment that we had given some time ago covers the different points that I have mentioned. I may have forgotten one or two.

What they need there is an organization, a Hospital Board that will adopt the standards that are laid down. These standards must be fair and must not be arbitrary. All must meet the same qualifications. Unfortunately for those who try to get in by short cuts they cannot meet the proper qualifications. That is the way

to bar them, and not because they are osteopaths, chiropractors or whatnot, but because they haven't the training.

Speaker Pyle: Let us stick to discussing the motion of the doctor: If—that is the question—this matter is to be referred to the Committee on Legislation and to the Council.

. . . The motion was carried. . . .

Speaker Pyle: Is there any other business that you wish to bring before the House?

Dr. Garner: In 1925 the State Legislature passed a bill giving the asylums of the state of Michigan the right to build and maintain open municipal hospitals. Three years ago the first unit was built in conjunction with the Northern Michigan Asylum at Traverse City. Following that, our State Board of Health recommended to different counties the employment of a full time health officer, secretary and nurse.

Some of the counties accepted it, others rejected it. A few points that I want to bring to you men is this, you have noticed through our papers that our county and state taxes are jumping rapidly. They have only started. If you stop to figure the enormous expense incurred by five or six large municipal hospitals under the management of the state that is only a drop in the bucket as compared with their maintenance. Also, figure in the extreme amount of money that is to be raised if both programs are finished, if all the counties in the state of Michigan accept a full time health officer, nurse and secretary together with the enormous expense for these hospitals, then what is going to become of the tax payer?

There are thousands and thousands of dollars in back taxes in various counties in the state of Michigan, and there are thousands of acres of land going back to the state every year. I have this one question to ask you men, if this program is completed what is the answer? What is the difference between a program of that kind and state controlled medicine?

It seems to me that it is a matter of vital importance because it is practically in its infancy. When the state makes a law it has control to enforce it. You have nothing to say about it and you haven't the power to control it. I would like to know just what the outcome of this thing is going to be when it is completed.

I want to move you that those counties that have not yet declared themselves be notified not to do so and that this matter be placed in a competent committee to thoroughly investigate and that nothing further be done until the state Society has decided as to what the best thing to do shall be.

. . . The motion was variously seconded. . . .

Dr. Biddle: This is a serious matter and I would like to hear from the Health Officer as to what the status is.

Speaker Pyle: Dr. Kiefer, do you wish to discuss this?

Dr. Kiefer: Mr. Speaker: I do not care to discuss the first part, the introduction to Dr. Garner's remarks, but I will be glad to say something about the balance.

In the first place there was never a law allowing the establishment of those units until 1928. It was then that the first law was passed, providing the Board of Supervisors of the County cared to allow them and allow the appropriation. It is entirely within the hands of the appropriation body of the county whether any money should be allowed for that purpose or not.

There was no state allowance for this purpose until 1929, this year, when the Legislature allowed a sum of $30,000, state aid, to be given counties that chose to establish such a unit, provided however that not more than $3,000 be allowed to any one county.

The State Department of Health is very strongly in favor of the establishment of such County Health Units for the reason that it is the only method by which proper public health work can be done in this state. It cannot be done from one central office. It is impossible to do it that way. In the southern part of the state they are pretty well organized for County Health Units. They conduct their work more efficiently than any one central office could.

As far as the expense and the tax part of it is concerned, that is the thing that we had to face before the Legislature. The State Department of Health asked for an appropriation of $60,000 for the purpose of giving state aid to the counties that chose to establish such County Health Units. It was cut down to $30,000.

The argument was if you want $60,000 now you will later want $100,000 and the first thing you know you will want a million and that is a lot of money. My answer was that the money wasn't to be used

unless the willingness of the counties showed that they wanted this thing and unless it proved worthwhile.

We have not asked any supervisor or any counties to establish any County Health Units, nor have we laid the possible value of it before them without first going to the County Medical Society laying before them our plan and asking them to endorse it, or not endorse it as they saw fit. We have never asked for a County Health Unit from the supervisor unless we first had the endorsement of the doctors.

We have further found out, as nearly as possible, when we got ready to go before the supervisor, how much money was being expended for unorganized health work in that county. We found almost invariably that they spend from $5,000 to $6,000 for a nurse to run around wild and not be supervised on some health work.

Our minimum estimate for a County Health Unit is $12,000. A county that is considering spending $12,000 has been spending $5,000 anyway. The state will furnish $3,000, the Rockefeller Foundation will furnish $2,500, so they are not going to spend any more money in the start of this thing than they did before they had it.

The principal advantage of a County Health Unit, if I may say so at this time, is its organization. We talk about health work that is to be done, health work that has been done, but you cannot do it unless it is properly organized and organized by an M. D. in charge of the work. That is the strongest thing in favor of it.

These doctors who take charge of the County Health Units are appointed by the Board of Supervisors. Never yet has one been appointed without our having been asked for a recommendation as to his qualifications. In each case we have been able to recommend a man who has had some training, through the Rochefeller Foundation, in county public health work.

We have a training school connected with our department in Lansing now and most of that is paid for by the Rockefeller Foundation. That is for men who want to take up this work.

We believe that a County Health Unit will do what it is my earnest wish can be done and will be done, it will turn the practice of medicine—and I am not talking about preventive medicine—over to the doctors. The County Health Unit will succeed in, I am sure, informing the public that what they want to do is to go to the doctors to have their children and themselves examined and have everything done that has, up to this time, been done by the Department of Health and which shouldn't be done by them.

We advocate no clinical work by the County Health Units. We have said in the past, and I think it will bear repeating, that when clinics are given at this time in public health work they are done for demonstrative purposes. That should be just exactly what they are done for. As soon as it has been demonstrated and the people find it out and know what needs to be done they should go to the doctor and have him do it for them.

What we need from the doctors to make this a success is their co-operation. If they will just sit by and say that these fellows are going to take their business away from them they are not going to do any good and "it is going to cost us a lot of money by taxation" then it is going to fail. But, if they will take hold and do the work that these County Health Units will teach the people should be done then it will be a success.

The result will be a much larger and more satisfactory practice of medicine for everybody that is in the game than there is now. (Applause)

Dr. Baumgarten: I would like to ask Dr. Kiefer one question, if I may, and that is this: In what respect does the operation of the full time County Health Unit, as proposed in the state of Michigan, really differ from the operation of, for instance, the very much howled-down Shephard-Towner Bill of a year or two ago?

A great many of us are ignorant of this subject and I think we want the low-down on it. If it is a bad thing we do not want it; if it is a good thing we do. Everybody was opposed to the Shephard-Towner Bill and President Coolidge took care of the matter for us and did away with it. I would like to know what the difference in the principle of operation is in the two.

Dr. Kiefer: The Shephard-Towner Bill and the money it appropriated was appropriated for the purpose of reducing, as much as possible in the states which adopted it, the unusually large and unnecessarily large infant mortality by teaching the public how to take care of their children and by having clinics established which did that very work.

Demonstration of that has been had in Michigan. We are not going to continue that at all. We want the doctors to do

it. The demonstration showed the people that it must be done. It had the result of reducing the infant mortality.

The money under that bill was allowed for five years if the states would care to match it and take it up. Then it was allowed for a subsequent two years with a sort of gentleman's agreement that it would not be asked for again.

I want to say to the House of Delegates that the state of Michigan was not represented in this plea for further money for this purpose. We said it must be continued through the doctors. We were perfectly willing to keep on with the educational work through our Bureau which was established—and I am perfectly willing to tell you—with the help of the Shephard-Towner money. It is established that the state will keep on doing the work that needs to be done in the way of educating the public through our Bureau but turning the clinical work that comes from that education over to the doctors.

The difference between that Bill and the work of the State Board of Health or the Local Boards of Health, if they are established, is that under the Shephard-Towner Act the actual clinical work of trying to keep babies well and reduce the infant mortality, and everything that went toward that purpose, was done by the money provided by the Shephard-Towner Act.

It isn't going to be done that way here, but it is going to be done by the doctors if we can succeed in making these a success.

Dr. Connelly: May I ask Dr. Kiefer if Act 306 does not provide that the proposed County Health Unit is not allowed to make use of the facilities at hand under the control of the Board of Supervisors? In other words, that refers to hospitals or already established clinics. Doesn't the bill provide that they may make use of the equipment that is already established?

Dr. Kiefer: Without looking it up I would have to say, no. At least I do not remember that it does. I do remember the section in the law that the County Health Unit shall operate under the general supervision of the State Department of Health and as long as they will follow our policies they will follow the policies that I have outlined here. If they do not do that they will simply not be following our policies.

There are at present four County Health Units in the state and only one of them has kicked over the traces and does some of the things that you men do not like and which I do not like. They keep promising to reform. They were established without a law before there was even a law in existence. They have a lot of money to spend and they will have to begin getting results. I am opposed to that. I do not see how any County Health Unit under the law—and they report to us every month what they are doing—could go far out of the way. I do not think the law allows it.

Dr. Insley: Section 6 of this Law or Act 306 not only provides for the supervision but for the control. I wonder if Dr. Kiefer remembers that section. It mentions that this board is given the power to control that.

Dr. Kiefer: The Board of Supervisors has the power to control, through the Board of Supervisors who give them the money and all that, in Section 6, the spread of communicable diseases.

Dr. Kiefer: I should hope they would have that right.

Dr. Insley: I would like to know if that is anything more than just simply demonstration?

Dr. Kiefer: You have to control contagious diseases.

Dr. Insley: That is a public health policy, but I am speaking of the Act alone which was brought up.

Dr. Kiefer: The Act is controlled by the State Department of Health.

Dr. Insley: I am speaking of Section 6 of this Act and of the power to supervise the activities in connection with the control of communicable diseases. It says there "control".

Dr. Henderson (Interrupting): I would like to ask Dr. Kiefer what constitutes a County Health Unit.

Dr. Kiefer: A minimum County Health Unit as we recommend it consists of a Health Officer, who must be a Doctor of Medicine, at least one and preferably two nurses and a clerk. If the thing is worthwhile and it works out well it is up to the County if they want to increase that number.

Dr. Henderson: You say three? All right, then the fourth one doesn't function. Is there any way that you can make the fourth one function?

Dr. Kiefer: I am doing my darndest to do that. I think so. I think there is some way of doing it.

Dr. Connelly: I would like to ask if

there isn't a possible danger in this establishment of the County Health Units. Suppose we should get a State Commissioner of Health in there who was a little more interested in self than in the medical profession, isn't it possible that this could be made a very good stepping stone for state medicine?

Dr. Kiefer: That is a big question.

Dr. Connelly, from my viewpoint of what public health is and what it should do I do not see how any man who is an efficient Health Commissioner could possibly conceive the idea that he should overthrow these principles of trying to get preventive medicine turned over to the doctors and try to do it himself. I cannot promise you that there won't be somebody who would do that. I think he would be wrong, however, and sentiment would be against him. The appropriation of the Legislature would go against him. I do not think he would get away with it.

I am trying to make a success of my job. The success of preventive medicine handled by a public official is to get the people educated that certain things can be done for their health first of all. Of course, a lot of that has been done but a great many things can be done to prevent diseases among them. When they get to that part the fellow who does that is their doctor.

I was talking to one doctor not long ago and he asked, "You want to prevent it among the school girls?"

I said, "Yes."

"The way to do it is to go into the schools."

That is what I call the old-fashioned health officer. That thing is going to be killed. There is one in the state whose appropriation has been taken away from him and he is all through.

The fellow who says the thing to do is to get the doctors to do this thing is the fellow whose ideas and policies is going to hold. That is what the people and you fellows want. That is the reason I do not think anything else is going to go through, not because the fellow doesn't want what you say but he won't be able to get away with it.

Dr. Connelly: That has been the big problem in the minds of the men reading and studying this proposition, whether a future Health Commissioner might not use that as a step for himself.

Dr. Kiefer: I do not think he could get away with it. I do not say he wouldn't want to do it.

Dr. I. W. Greene (Shiawassee): It strikes me that this would be a very unwise thing to tie the matter up for another year as it would be if it was handed to a committee. It impresses me that this is a local matter and not something that the State Society should decide itself.

There are some counties where the local health unit would be a fine thing. If any of you men have had contact with some of the small town health officers and know them you know that they cannot function efficiently. Under those conditions the Health Unit is going to be a fine thing.

Different counties may see the situation differently. We talked today about reviving our country societies and making them more of an influence in medicine. Suppose we give them a little chance to settle this question, because it is a local matter.

I think we talk altogether too much about state medicine. If we would talk a little more about practicing good medicine we would be standing better with our communities. We go to our Legislature and they accuse us of being selfish. Maybe they are a little bit right about it. I have a hunch that these people who talk about state medicine look at it from a selfish standpoint.

We are appointing a committee to educate the laymen. I do not know any organization that will have a better influnce in educating laymen to the usefulness of good medicine than an efficient Health Officer. I believe that the State Society, as a whole, would find it advisable not to tie themselves up with this question.

Speaker Pyle: Is there a further discussion?

Dr. Garner: I would move that this matter be placed in the hands of a competent committee to thoroughly investiate it, and that the counties be requested not to take further action until the State Society has decided the matter. That is my motion.

Speaker Pyle: You have heard the motion.

Dr. Connelly: I second the motion.

. . . The motion was put to a vote. There was a doubt as to the result. . . .

A rising vote was taken with the result:

For	12
Opposed	23

Speaker Pyle: The motion is lost.

Dr. J. R. Rupp (Wayne): I am sure

the House of Delegates is interested in the welfare of the profession in Michigan. That is reflected in how our young physicians are getting started. The needs of a physician starting in a big city are great and there are inroads on his practice. Sometimes I think we ought to take down all the Safety First signs so that they will have a little business.

We are going in for the practice of preventive medicine if the County Health Units are going to function, and under the wonderful guidance of Dr. Kiefer they will. I only think they might take over the practice of medicine as well. I do not believe that will necessarily occur.

If we could have the advance agents and the visiting nurses talking for the offices of the physicians and once a year dropping in with a poor charity case which he would be glad to treat, nine out of ten of the charity cases would be taken care of by the physicians themselves and they would be tickled to death to do their own charity work. They would be glad to do some of those cases and have them serve as advertising to their own offices. I think we should get that over so that the offices of the physicians may be built up and may become the health centers they should be. We have thousands of them all over the state. Let us put forth the effort to have the business go to them.

I think if the Rockefeller Foundation is interested in helping the families, I would like to say that some of the families of the physicians are at the point where they haven't much to eat.

I would make this motion, in order to get this matter before us in a way that we can better grasp it— and if we are going to practice medicine let us have a uniform price for it. The Scotchmen and others so inclined can get their services a little cheaper in some groups or in the free clinics if they go with the right sort of story. I think if they are making $10,000 a year or so they should be compelled to pay for the care. If the investigation is done by the doctor himself then it is entirely different. Of course, if those people come with the right sort of a story they can get free medical service.

Of course, if they get caught in the story they cannot get the free service until they have tried to get it from the physician and he gives them a letter saying they are entitled to the free service.

I would like to make this motion: Resolved, that it is the recommendation of the State Society that no physician should give services to any patient in a free clinic unless same patient has been referred there by the written order of some other physician. This shall not exclude any temporary first aid treatment.

I think our public hospitals—if I might speak another word on this — should be entitled to just the same ethical advertising that a private hospital has a right to have. I think that is a wonderful hospital that was started in Detroit in the northwest section where there are a group of private physicians. I am not in with them, although I admire their bravery. I didn't hear much about that, but when the Receiving Hospital Unit was started there were big headlines in the paper on that. There was something like $117,000 spent for a 25-bed unit. I think there should be the same standard for the public institution that we have for the private unit. I think the private institute is entitled to as much advertising as the free clinics and the receiving hospitals.

There was an incident where a man crushed his finger working on a job and he was the first patient there. There were some 100 doctors in that same community. One of the young physicians said he had waited on that same corner for three months without a call. Any one of the physicians in that community would have given the same service at the expense of that particular insurance company that was responsible for that accident. Instead of that the welfare workers of the city of Detroit think it has been a wonderful investment to put $117,000 into a 20-bed hospital. Where are we coming off?

. . . The motion was variously seconded among the Wayne County delegation. . . .

Speaker Pyle: The motion, in full, then is:

"Resolved, That it is the recommendation of the State Society that no physician should give service to any ambulatory patient in any free clinic unless such patient has been referred there by the written order of some physician. Dismissal from his local society should be the penalty for such violation. This shall not exclude any temporary emergency for first aid treatment."

You have heard that motion, is there a discussion?

Dr. McClintic: I think that some of these resolutions are rather hastily drawn up. The objection that I had to Dr. Garner's former motion was the fact that he

said no county and I took it to mean the Board of Supervisors. He said the Society should go on record, and the County Medical Society be asked not to establish a clinic or a Public Health Unit until after the investigation had been made. In that case I think it might be proper.

I think there are men here who can subscribe to the principle of the motion just made. I can see that something may arise where that would work a hardship on some individual who might be in a position where he needed treatment and it might not be emergency treatment.

I can conceive of individuals in a large city like Detroit needing free clinical service. They may be in dire need of the attention of a physician. Their condition may not be chronic and it may not be an emergency and it may not be an acute case. However, I see no reason why that patient should be turned away from the clinic and sent off to a doctor who will eventually send him back to the clinic. He may go to a doctor who really doesn't want to see him. We have some patients we would rather not see coming to us; we would prefer to see them go to the clinics.

On the other hand, the penalty attached there, it seems to me, would require a change in our by-laws or in some of our ethics. For that reason I think it raises quite a serious problem. It seems to me that it should be referred to a committee and permitted to lay over and be taken up at the next meeting of the House of Delegates.

I move that that be referred——

Speaker Pyle (Interrupting): There is a motion before the house. However, I think a motion to refer to a committee is in order.

Dr. A. J. Himmelhoch (Wayne): I would like to say a few words about the motives behind the resolution that has been offered. This may not apply so strikingly in other counties, but Wayne would like to have the support of the Society in a measure which they hope will put an end to a situation which is at present almost intolerable and which seems to be getting worse.

Those who practice in the larger cities know that the younger men all want to be on the staffs of the good hospitals in the city. In order to be on the staffs of the good hospitals they have to work in the clinics. No doctor, young or old, objects to seeing any patient who needs medical services.

On the other hand, the classification of patients into indigent groups and those who can afford to pay is at present carried on by social workers who are very well paid and whose classification of a needy patient would not agree with that of most doctors who are practicing.

Dr. Baumgarten will perhaps follow with a little discussion as to an article which appeared in a recent issue of the American Journal of Surgery in which one of our Detroit social workers, Miss Kaiser at the Harper Hospital, spoke on the need of clinics to take care of patients who are quite indigent. Here I wish to say that her definition of an indigent patient included those who were in many instances in a better position than the average doctor.

If the individual doctor in a dispensary were to object to seeing the patient he would be given the alternative of seeing the patient or leaving the hospital. Neither of those alternatives would be desirable.

On the other hand, if the situation were put to the hospital that no doctor could belong to the local medical society and see patients in the hospital if they were not approved by the physicians themselves it would make it much easier for the men on the hospital staffs.

I can speak for a number of men who are at present seeing patients in dispensaries and who are constantly complaining of the attitude of social workers in regard to who should and who should not be seen.

The doctors do not see where a hardship would be worked on either the patient or the physician if they required every patient who came to a free clinic to have a slip from a physician saying he had taken care of the patient, or he had seen the patient, knows the circumstances and feels the patient is entitled to the care of the clinic. The doctors would then be willing to see the patient. They would then not have to depend on an elaborate social service scheme which is exceedingly expensive and in which every unit is paid except the doctor and which is constantly taking away cases from the practitioners which really should form the bulk of his practice.

Speaker Pyle: Dr. McClintic made a motion to refer this matter to a committee.

Dr. McClintic: To the Public Relations or Ethics Committee.

Or, I might suggest the Committee on Miscellaneous Business.

. . . The motion was variously seconded. . . .

Speaker Pyle: The chair would like to ask for information from some parliamentarian as to whether a motion to refer to a committee is now in order.

Secretary: A motion to commit is always in order and is non-debatable.

Speaker Pyle: The chair will ask for a vote on this, whether it is the sense that a motion to refer is in order in spite of the discussion.

Dr. McClintic: I understand that a motion to commit a resolution of that sort is always in order and is non-debatable.

Speaker Pyle: The chair will rule in that fashion. The question is to refer this motion by Dr. Rupp, regarding these clinics, to the Committee on Miscellaneous Business.

. . . The motion was put to a vote. The result was in doubt. . . .

. . . The motion was put to a rising vote with the following result:

Favoring	16
Opposed	17

Speaker Pyle: The motion is lost.

. . . The vote on the original motion was called for. . . .

Dr. R. H. Denham (Kent): I think we all realize that there is a possibility of some patient being bled and being put off by some unscrupulous man to whom he may have gone, even though that patient should have charitable services. They may not get a reference card until they are bled so far that they suffer. I think we should consider very carefully before we adopt this resolution.

Dr. Himmelhoch: That question was thoroughly discussed when the motion was being considered. Any patient has a right to go to another physician if he, or she, wishes. If he goes to a physician and that physician refuses to send him to a clinic he can go to another physician and submit the case to that physician. It is not likely that he will fail to find any physician who will see no justice in the case.

Again, it has been suggested that every local society will surely form a committee to take up the case of those physicians who are negligent in either direction, that if it can be shown to the committee that a doctor is bleeding the patient and is not conducting himself—well, I do not think any doctor would want to be put into that class. I do not think any injustice will go unnoticed. There will probably be abuses in the other direction too.

If clinics can show that doctors are sending them cases for X-ray or for laboratory work which ought to be paid for then that too can be corrected. There is no reason to believe that any indigent patient will suffer. It will tend to eliminate a tremendous expense in the running of hospitals.

The social service investigation which at present is so expensive is getting more expensive, involving more and more workers and larger and larger salaries, a large part of that will be taken over by the physicians themselves. That type of worker can be put on work which is more helpful to the patient himself.

Dr. Rupp: I wish to answer what Dr. McClintic said. This is not a hastily drawn up matter. This has been boiling in me for some time. I have discussed it with numerous physicians, some of them in Toledo and other places. I have been told that the Toledo Medical Society, which is one of the liveliest organizations in the country, has had such a system in force for a number of years.

There the Visiting Nurses' Association was running a bill of some $15,000 a year for nurses' calls to homes. They were drumming up business for the Receiving Hospital and the free clinic. The Medical Society says that no nurse shall visit a patient's home unless she is so requested. That cut down the expense from $15,000 to $1,500 and saved the tax payers some money. It is up to us to get some lay organizations to see that we are fighting their problems and let them take it up too.

There is the other question that this might be a hardship for some. This will not be. It has been provided for that temporary emergencies can be taken care of. However, let that be temporary and not a continuation. Bleeding fingers need not be amputated. You can send the man to the private physician who will amputate if need be and he can also do anything else that needs be done.

Dr. A. D. Allen (Bay-Arenac-Iosco): I move we adjourn.

Speaker Pyle: A motion to adjourn is always in order.

. . . The motion was seconded variously. The result of the vote was in doubt. . . .

. . . Tre rising vote was taken with the following result:

Favorable	16
Opposed	22

Speaker Pyle: We are still in session.

. . . The question was called for. . . .

Dr. Biddle: I would like to ask a question. I am perfectly in favor of what they say about a clinic. I think, however, that the penalty attached is entirely too severe. The question of penalty rests with each Society. I think if the doctor will withdraw the penalty I can vote for it, but with the penalty attached I cannot. He has no right, and we have no right, to set the penalty. That is an individual question to decide. I would like to ask the doctor if he would be willing to withdraw that penalty.

Dr. Rupp: I am willing to change it. I had in mind a case where a young physician was arguing with the social worker about the treatment of a certain case. He probably couldn't get enough force there to back him up and to convince the social worker that that was a case for the doctor. He might, if this were in effect, say, "My County Society will not stand for my taking care of the patient on that basis." He would have a weapon there.

You might say that he would lay himself open to disciplinary action by his local Society.

Speaker Pyle: You have heard the question and the modification. Will you state it, Dr. Warnshuis?

Secretary: The resolution was:

"It is the recommendation of the State Society that no physician should give service to any ambulatory patient in any free clinic unless such patient has been referred there by the written order of some physician.

"Members violating the provisions of this motion are to be referred for disciplinary action to their County Society. This shall not exclude any temporary emergency or first aid treatment."

. . . The motion as stated by Secretary Warnshuis was carried. . . .

Dr. Baumgarten: Our President, in his address this morning, stated some hard work is being done by various members of the State Society, with particular reference to the Secretary. He also stated that some provision ought to be made whereby a secretary be a full-time man or else be compensated in such a manner that it will pay him to take up his time.

To bring this before the House of Delegates, I would move you, Mr. Speaker, that it is the consensus of the House of Delegates that the present Secretary be retained at a salary of $1 per year and that a full-time Executive Secretary be hired, the salary and responsibilities of such a secretary to be fixed by the Council.

. . . The motion was seconded. . . .

Dr. H. E. Perry (Luce): We voted awhile ago to appoint a committee to revise the by-laws of this Society. I think this motion should be referred to that committee, the Committee on the Revision of the By-Laws of the Society.

I would offer that as an amendment to the motion.

Dr. Allen: I support that.

Dr. Baumgarten: It is my belief that this committee to revise the Constitution and By-Laws is appointed at this session and that it is to report a year from now. Conditions are such, as I understand them, that we cannot wait a year for action with regard to the secretaryship. I think it would be better to take this matter up at this time rather than refer it.

The President, in his address, stated that the Council should appoint a Secretary and that the Council should act in accordance with the way the House of Delegates acted.

Dr. W. C. Ellet (Berrien): Does that mean a lay secretary?

Speaker Pyle: Then you do not accept the doctor's amendment?

Dr. Perry: My amendment is that this motion be referred to the Committee on the Revision of the By-Laws for consideration.

Dr. A. A. McKay (Manistee): I would like to second that.

. . . The amendment was put to a vote. There was a doubt as to the outcome. . . .

. . . The result of a rising vote was:

Favorable	17
Opposed	13

Speaker Pyle: Now we will vote on the motion as a whole.

Secretary Warnshuis: You have moved to commit it and that is where it is now.

Dr. Baumgarten: It seems to me that the amendment was negative to my motion. It has nothing to do with the motion at all. I believe that defeats the motion. I would rather see the motion defeated than have it go through in that way. The matter was brought up to take care of this year and isn't contrary to the constitution in any way.

Speaker Pyle: A motion to refer the matter to a committee is in order and it has been carried. The chair must rule that way.

Dr. Ellet: I move we adjourn.

. . . The motion was variously seconded and carried. . . .

. . . The meeting adjourned at five-fifteen o'clock. . . .

TUESDAY EVENING SESSION

SEPTEMBER 17, 1929

The third session of the House of Delegates convened at seven forty-five o'clock, Speaker Pyle presiding.

Secretary: I hold in my hand the signed roll call of more than a quorum of the House. I move that this roll call constitute the official roll call of the House for this last session.

. . . The motion was seconded and carried. . . .

Speaker Pyle: Has the Reference Committee anything else to report supplementing the afternoon report?

Dr. Shaw: We have nothing to report.

Dr. McClintic: We have nothing further to report.

Dr. Andrews: We have nothing further to report except that this request was handed to me: Would the committee be willing to thank the contributors to the Medical History, as well as the committee themselves?

Speaker Pyle: That can be incorporated in your motion.

We will now listen to the report of the Nominating Committee.

Dr. J. J. O'Meara (Jackson): Dr. Cassidy was kind enough to appoint me to read this report. Your Committee reports:

ELECTIONS

For First Vice President, George F. Inch.

Second Vice President, Claude R. Keyport.

Third Vice President, E. H. Webster.

Fourth Vice President, W. C. McCutcheon.

The Delegate to the A. M. A. was by a majority vote for Dr. Moll. He was nominated for that position. The alternate for the position was Dr. Cassidy.

The place for the next annual meeting was decided to be offered to you as St. Joseph and Benton Harbor.

Speaker Pyle: The next order of business is the election of these several nominees. First there are the four Vice Presidents of the Society.

Dr. McClintic: I move that the Secretary be instructed to cast a ballot for the four nominees.

Dr. A. V. Wenger (Kent): I second the motion.

. . . The motion was carried. . . .

Secretary: In compliance with the instructions of the House of Delegates your Secretary does cast the ballot of the House for Dr. George F. Inch, of Traverse City, Dr. Claude R. Keyport of Grayling as Second Vice President, Dr. E. H. Webster of Saulte Ste. Marie as Third Vice President, and Dr. W. C. McCutcheon of Cassopolis as Fourth Vice President.

Speaker Pyle: I declare these gentlemen elected.

Now we have the question of the Delegate to the A. M. A. Dr. Moll has been nominated.

Dr. A. S. Brunk (Wayne): There is a man who has given a great deal of time to the Society's affairs this last year and he has made a brilliant success. I believe this organization could not do anything other than elect him as our National Delegate this year.

I nominate Dr. Louis Hirschman, our retiring President, for Delegate to the A. M. A.

Speaker Pyle: Are there any further nominations?

Dr. Baumgarten: I move the nominations be closed.

. . . The motion was variously seconded. . . .

. . . The motion was carried. . . .

Speaker Pyle: We will now proceed to ballot for the two candidates. We will appoint five tellers. They are to be composed of the three gentlemen sitting on the left here and the first two on that side.

. . . Balloting proceeded. . . .

Speaker Pyle: Has everybody voted who wishes to vote? If so, I declare the ballot closed.

We will now listen to the report of the tellers.

Secretary: There were 50 votes cast. Dr. Moll receives 27 and Dr. Hirschman 23.

Speaker Pyle: That declares Dr. Moll as Delegate to the A. M. A.

Now we come to the election of the Alternate. The nominee is Dr. Cassidy.

Dr. Wenger: I move the rules be suspended and Dr. Cassidy be elected by acclamation.

Dr. G. H. Southwick (Kent): I second that motion.

Dr. Dibble: I wish to nominate Dr. Hirschman as Alternate.

Speaker Pyle: We have had a motion, gentlemen.

Dr. Carstens: Time must be given for nominations to be made from the floor.

Speaker Pyle: I yielded the floor to Dr. Wenger and he has made a motion which has been seconded. That motion is before the house.

Dr. Wenger: I will yield the floor.

Dr. McClintic: I am under the impression that you cannot deprive him the privilege of the floor if he objects before the motion is put.

Speaker Pyle: Dr. Dibble, you have the floor.

Dr. Dibble: I nominate Dr. Hirschman.

Dr. McClintic: I second that nomination.

Speaker Pyle: Are there any other nominations? If there are no other nominations we will proceed to ballot. The same gentlemen will act as tellers.

. . . Balloting proceeded. . . .

Speaker Pyle: Gentlemen, have you all voted? I declare the ballot closed.

We will now listen to the report of the tellers.

Secretary: There were 52 votes cast, of which Dr. Cassidy received 26 and Dr. Hirschman received 26.

Dr. Hirschman: I wish to withdraw my name.

Speaker Pyle: According to the constitution the Speaker has no right to decide a question of this kind. What are your wishes, gentlemen?

Dr. Wenger: I move we proceed to another ballot.

Dr. Brook: I second the motion.

. . . The motion was carried. . . .

Dr. McClintic: I rise to a point of order: Our by-laws provide that in case of a tie vote the Speaker shall cast a vote to declare which shall be elected.

Secretary: Mr. Speaker and Gentlemen of the House, with your indulgence I will see what Robert's Rules say. In the A. M. A. the provision in the by-laws is that in case of a tie vote the Speaker casts the deciding vote. However, in our Constitution and By-Laws there is no such provision. Our Constitution and By-Laws do provide that Robert's Rules of Order shall govern the parliamentary procedure of the House. I will look up what it says on a tie vote.

Mr. Speaker and Members of the House, this is Robert's Rules: "On a tie vote the motion is lost, and the chair, if a member of the assembly, may vote to make it a tie unless the vote is by ballot. The chair cannot, however, vote twice, first to make a tie and then give the casting vote. In case of an appeal, though the question is, 'Shall the decision of the chair stand as the judgment of the assembly?' a tie vote, even though his vote made it a tie, sustains the chair. . . ."

According to Robert's Rules your Speaker cannot decide and hasn't the power to cast the deciding vote.

. . . Balloting proceeded. . . .

Speaker Pyle: If everyone has voted I declare the ballot closed.

We will hear the report of the tellers.

Secretary Warnshuis: There were 53 ballots cast, of which Dr. Cassidy received 29 and Dr. Hirschman 24.

Speaker Pyle: I declare Dr. Cassidy elected alternate.

The next question is the place of the annual meeting. The Nominating Committee have designated St. Joseph and Benton Harbor.

Dr. McClintic: I move that we decide to go to St. Joseph and Benton Harbor.

Dr. Wessinger: I second the motion.

Dr. Corbus: The Council is somewhat concerned as to the meeting place. I do not want to take a position against Benton Harbor or St. Joseph, but the Council would like to have a certain amount of latitude in the placing of this meeting for matters of economy if for nothing else.

There isn't time for the House of Delegates or the committee, in the brief time that they have, to thoroughly look into the matter of accommodations. The Council would wish that they be given some latitude. Understand, this isn't because we are not in favor of Benton Harbor or St. Joseph, but we feel the interest of the Society would be best served if we had the opportunity of having a certain amount of leeway.

Speaker Pyle: Is there any other discussion?

Dr. Himmelhoch: Is it the wish of the Council to have more latitude than that which is contained in the motion?

Dr. Corbus: The Council would wish you to give them a certain amount of latitude so that if we found conditions such that it might not be the best for the Society we might go to some other place.

Dr. Walter J. Wilson (Wayne): I make an amendment that "in the discretion of the Council" be added to this motion.

Dr. Himmelhoch: I second that.

Dr. Ellet: Isn't that a rather ambigu-

ous statement, to give the Council latitude? Have they named any other place?

Speaker Pyle: No other place has been named so far.

Dr. Ellet: It would give the Council the latitude to set the place of the meeting any place they wanted.

Speaker Pyle: We direct the Council and we let them go according to their own discretion. They could name any meeting place they wished.

Dr. Ellet: The House of Delegates would have no say as to where the meeting would be.

Speaker Pyle: Not if we delegated that power to the Council.

Dr. Hornbogen: It has been customary, in the American Medical Association, to designate the place, but the Board of Trustees very carefully investigate whether any town we designate is a suitable one for holding the meeting.

I think that is a very wise provision. We do not want to be gypped and we do not want to go to a place that hasn't the conveniences and the places to hold a proper meeting of the State Society.

I think we should follow the lead of the parent organization, the American Medical Association, and give our Council that much leeway. If we should go to some town where they cannot have a decent meeting, then we are all disgruntled and whose fault is it? Then it is the fault of the House of Delegates. I would like to pass the buck to the Council.

Speaker Pyle: Is there any other discussion on the amendment? The words "in the discretion of the Council" were offered as an amendment.

Dr. McClintic: Why can't that be worded more definitely? That is another one of those ambiguous phrases. Why not word it in such a way that unless an emergency arises, which in the judgment of the Council would deem it advisable to hold the meeting somewhere else, it will be held in Benton Harbor and St. Joseph?

The Council in that instance would have to show that there was an emergency existing. They would have to investigate that Benton Harbor could not accommodate the Society. There might not be hotel accommodations in Benton Harbor and St. Joseph and they could then move the meeting, but they would have to show that those facts exist before they could take the meeting away from there. That would put the burden of proof on the Council and would not leave the matter up to them merely.

. . . The amendment was voted on. The vote was in doubt. . . .

. . . The result of the rising vote was:

Favorable	41
Opposed	7

Speaker Pyle: The amendment is carried. The question now is on the original motion as amended, that we designate Benton Harbor-St. Joseph as our next meeting place, but that it be left to the discretion of the Council.

Is there any discussion on that motion?

. . . The motion was put to a vote and carried. . . .

Speaker Pyle: Now we are open for nominations for Councillor from the Thirteenth District.

Secretary: The Thirteenth District is the one where Dr. Van Leuven of Petoskey now is. It comprises the following: Alpena (including Alcona), Antrim, Charlevoix, Cheboygan, Emmet, Presque Isle. The delegates from that section are supposed to nominate their Councillor. I have had no nominations.

Speaker Pyle: Are there any nominations for Councillor from the Thirteenth District?

Delegate: The delegates from that District have caucussed and they have unanimously agreed to nominate the present Councillor, Dr. Van Leuven for another term of office.

Speaker Pyle: Are there any other nominations?

Dr. Wilson: I move that the Secretary cast a ballot for Dr. Van Leuven for Councillor from the Thirteenth District.

Dr. Mac Kenzie: I second the motion.

. . . The motion was carried. . . .

Secretary: Mr. Speaker, your Secretary does so cast the vote.

Speaker Pyle: Next is the Councillor for the Fourteenth District. But, first of all, I declare Dr. Van Leuven elected.

Secretary: Dr. Bruce of Ann Arbor is Councillor from the Fourteenth District which is comprised of: Lenawee, Monroe, Washtenaw.

Dr. Wessinger: I rise to nominate Dr. James Bruce to succeed himself. That is the unanimous verdict of the delegates of the three counties included in that District. Dr. Bruce has eminently filled this position in times gone by and he is only about half through with the work that he has outlined. We feel he is not only eminently fitted, but in justice to him we should reelect him.

Dr. R. G. B. Marsh (Lenawee): I second the motion.

Speaker Pyle: Are there any other nominations?

. . . The motion was carried. . . .

Speaker Pyle: I declare Dr. Bruce elected as Councillor for the Fourteenth District.

We are now at the point where we will take nominations for the Speaker.

Dr. Himmelhoch: I wish to put in nomination for Speaker Dr. Charles E. Dutchess of Wayne.

. . . The motion was seconded variously. . . .

Speaker Pyle: Are there any further nominations?

Dr. Moll: I wish to place in nomination Dr. Pyle to succeed himself.

. . . The nomination was variously seconded. . . .

Speaker Pyle: Are there any further nominations? It not, we will proceed to ballot. The tellers will come up.

. . . Balloting proceeded. . . .

Speaker Pyle: Gentlemen, have you all voted? If so, I declare the ballot closed.

We will now have the report of the tellers.

Secretary: There were 51 votes cast. Dr. Dutchess received 20 and Dr. Pyle 31. (Applause).

Speaker Pyle: Gentlemen, I have been visibly embarrassed today by my lack of knowledge of parliamentary law. The only reason that I didn't withdraw my name was because I thought if I were elected it would give me a chance to do the things right next year. I thank you! (Applause).

Nominations for Vice Speaker are now in order.

Dr. Himmelhoch: I nominate Dr. Dutchess as Vice Speaker.

Dr. Southwick: I second the nomination and move the nominations be closed.

. . . The motion was seconded and carried. . . .

Dr. Wilson: I move the Secretary cast a ballot for Dr. Dutchess for Vice Speaker.

Dr. Wessinger: I second the motion.

. . . The motion was carried. . . .

Speaker Pyle: I declare Dr. Dutchess elected.

Secretary: Mr. Speaker, your Secretary so casts the vote.

Speaker Pyle: Is there any unfinished business?

Is there any new business?

Dr. Biddle: There are so many things of importance that were brought before the House of Delegates to decide in this one day and they have such a far reaching effect not only within ourselves but as regards the layman, that I was wondering if it wouldn't be wise for you to appoint your committees long before this meeting and submit the different reports to them for consideration so that instead of having two or three hours for consideration of very important matters we may have at least one or two months.

I was wondering if it would be practical to have those committee reports submitted to them and any other resolutions that may be offered. If it is not practical I withdraw my suggestion.

Secretary: Dr. Biddle and Members of the House: The suggestion of Dr. Biddle is entirely in order. Before an annual meeting we attempt to secure the reports of our standing committees and special committees that are functioning through the year. We publish them in the Journal a month preceding the annual meeting.

It is true, as Dr. Biddle says, that in the short period the House has for consideration of some of these important reports, like that of the Industrial Committee which was submitted today, it is almost a necessity that in order that the members understand this report some kind of an intelligent abstract must be presented to the House.

The policy in the American Medical Association is—by precedent and not by constitution and by-laws—that the Speaker appoints his reference committees one month preceding the annual meeting of the American Medical Association and all committee reports are referred to the special reference committees, appointed by the Speaker, and all resolutions as far as possible are sent to the Secretary of the American Medical Association a month before the annual meeting, and they are published either in the Bulletin or the Handbook of the American Medical Association in order that the delegates may have the opportunity of going over these reports and thus be in better position to vote intelligently on the action of the Society.

The suggestion of Dr. Biddle is a timely one. It might well be handled by the House, that a resolution be introduced at this time that it be established as a precedent of the House that all committees be appointed one month previous to the time of the annual session, by the Speaker, and all reports be referred to the reference

committees, appointed by the Speaker at that time, and that all resolutions of members, having this in mind, be referred to these same committees, or to the Secretary to be referred to these same committees, and be published in the Journal as well as in your Handbook so that the delegates may be able to digest them and be more intelligently informed when they make their vote.

Dr. Biddle: I make such a resolution that you so instruct them.

Dr. Mac Kenzie: I second the motion.

Speaker Pyle: Is there a discussion? . . . The motion was carried. . . .

Speaker Pyle: Is there any other business?

Dr. Carstens: This afternoon the House discharged a committee that has done by far the largest amount of work that any of our committees have recently done, the Legislative Commission.

I wonder if we have been properly appreciative of the tremendous amount of work done by our Legislative Commission, by the officers of our State Society, and by certain Legislative Committeemen from some of the County Societies? Some were active and some were not. Most of us had reports from time to time. We are all interested in how they are going along. We know they have troubles and that this work takes a tremendous amount of their time. Almost every officer and every member of the Legislative Commission was on the job constantly.

I move the House express, to the members of the Legislative Commission, the general officers of the Society and those members of the County Societies who were active in the legislative work, our thanks and appreciation for the work which they have done in the last year.

Dr. Biddle: I second the motion.

. . . There were several other seconds as well. . . .

Speaker Pyle: Is there any discussion? . . . The motion was carried. . . .

Speaker Pyle: Is there any further business?

Dr. Denham: This afternoon when there was less than a full session here, a measure was passed in this assembly which, it seems to me, is of considerable importance and is one that deserves to be considered by the whole assembly. That was the question of the treatment of charity patients, or patients, whether charity or not, in free clinics.

If you will, I would like to have you read that motion as it was passed.

Dr. Baumgarten: We are now under the title of New Business in the order of business. This matter that is being brought up now has been passed upon and doesn't have to be reconsidered. If some of the delegates left prematurely it is their own fault.

Speaker Pyle: A motion to reconsider, doctor, is always in order.

Dr. Baumgarten: There is this point, that in the last session of the House of Delegates there was the order that in order to bring up business of this nature we have to have the unanimous consent of the delegates seated.

Speaker Pyle: This is the reconsideration of a motion, doctor, and the chair feels that it is in order.

Secretary: The motion was:

"It is the recommendation of the State Society that no physician should give service to any ambulatory patient in any free clinic unless such patient has been referred there by the written order of some physician.

"Members violating the provisions of this motion are to be referred for disciplinary action to their county Society. This shall not exclude any temporary emergency or first aid treatment."

. . . There were several seconds to Dr. Denham's motion to reconsider. . . .

Speaker Pyle: It is moved and seconded that this resolution be reconsidered. . . . The motion was carried. . . .

Speaker Pyle: The resolution is now before the House.

Dr. Denham: Mr. Chairman, there is no question but that those men living in Detroit have a just grievance. Such is not the case in the smaller towns, or cities. One can readily see where it would not always be well that a patient be referred by an attending physician.

Personally, I do quite a little clinic work. I know that the clinics are abused, but we cannot get around all of the abuse. We can get around some of it. I see charity patients in my office who have been severely abused and who have been bled by attending physicians who have taken their last dollar and have taken more than they could afford to spend before they would turn them loose for charity clinics.

Very often, I am afraid, these patients are not going to receive the proper treatment. It strikes me that this matter could be dealt with in the local Society. It is

a local problem, more or less. It isn't a problem that confronts all of the Medical Societies of the state.

It is for that reason that I suggested this be reconsidered. The penalty as read there is less severe than the one first offered. The penalty could be very severe. It seems to me that it might be more severe than the punishment of crime. For that reason I would like the whole House of Delegates to consider this matter.

Dr. Himmelhoch: Having spoken in favor of this motion this morning I am taking the liberty of speaking to it this evening.

Like Dr. Denham I spend every morning of the week in the free clinics. I do not speak as one on the outside looking in. In a similar way Dr. Whittaker and several of the others, in favor of the motion, also devote at least half their professional time to the free clinics.

There is no question that in the smaller communities the problem which presents itself in a city like Detroit is not present.

In the first place I might answer Dr. Denham's reflection on the members of the profession—if we are prepared to say that we include among our numbers people who are willing to believe the patient should be abused and who treat him in a way which reflects discredit on our organization—that if we recognize them as our honored members in the profession then we are in a weak position.

We should start with the assumption that all of our members are honest and none of us wants to bleed the patient. We all want to give the patient the best kind of medical attention and yet not give away services which are worth adequate remuneration to people who are able to pay for the services.

Nobody in the Wayne County group is at all prepared to demand fees from indigent patients. Doctors have always been and all medical men—and we are talking about the kind of medical men we hope we are —are only too glad to give the indigent patient the best that is in us. We see them in dispensaries and we give them more time and more conscientious attention than we do to the patients in our office sometimes.

When we are confronted by the patient who comes there in an automobile wearing a fur coat, and who is buying a radio, in many cases in a stronger financial position than is the physician himself, one who has nevertheless been admitted to the clinic on the basis of a social worker's decision as to his or her ability to pay, then I think it is time for us either to admit that we are not prepared to judge a patient's ability in any direction to pay and leave it entirely up to social workers.

We have good hospital workers and conscientious social workers in every hospital in Detroit, and we have an elaborate social service apparatus which is expensive, just as expensive as any medical apparatus in the state. The cost for social service in a hospital is tremendous. The cost for medical service in the hospital is nil.

Social workers see patients at the desk. Those patients can come with any story they like. They lie in many instances. In many instances they tell the truth and yet the social worker decides that the patient is able to pay, and we as physicians would be willing to admit that patient because he is unable to pay.

The social worker will tell you that the patient is so tied up with debts on radios and automobiles and jewelry that he is in no position to pay the doctor. We ask only the same consideration for the doctor in the clinic that the grocery man, the radio dealer and the automobile dealer get. There is no reason for us to be treated as good things by social service workers and organizations, professional charity dispensers who are themselves very well paid.

If an individual physician were to go to the hospital in which he works, we will say, for instance, Harper Hospital in Detroit where I work with Dr. Whittaker and a number of other men who are in the delegation—and we have no complaint to make against the hospital because it is well organized and the physician is treated in as fine a way as it is possible for him to be treated.

However, it would be perfectly impossible for any individual or any small group of physicians to go to that hospital and say, "You people are hiring a large group of social workers at a tremendous expense and you are giving free medical service for patients whom we know are able to pay. We do not like to continue, we are willing to see indigent patients but not those who can pay."

The social workers would probably say, "You must realize that you have come to this hospital of your own accord. If you do not like the way things are you are always at liberty to leave."

If the County Society put the proposi-

tion in this way that no member could remain a member of his—if it were necessary to be that drastic(and it might not be necessary at all in the smaller counties) —Society or in good standing who would work in a clinic except on those cases that had a doctor's certificate that they were indigent, I think something could be done. That would mean that the doctor would have to see him in his office for nothing. He would have to see him many times for nothing.

If the physicians are unwilling to make single visits for nothing then they ought to turn this down. Most physicians would be willing to make a visit to a patient and then finding that the patient is indigent he will give that patient a slip to go to the hospital. That would work no hardship on anybody.

If the person was indigent and he went to one doctor and that one didn't think he needed help then the person could go to another doctor. Then if they found two or three didn't consider them they could take it to the County Medical Society and they would handle the unfair doctor as they saw fit. Every deserving patient would get free medical service just as they are receiving it now. It would rule out those not deserving free medical service.

The Bar Association had a convention in Detroit recently. They have begun to think about the question of free legal aid. They do not admit that anybody who comes recommended by a social worker is entitled to free legal aid. They are going to give free legal aid to any person who, in the opinion of the Bar Association is entitled to free legal aid.

There is no hardship that is going to be worked on anybody. The only thing it does is give some solidarity to the profession so that they are not acting as single agents to overcome an evil which is a very real one in the cities and which is working great hardship on the profession. (Applause)

Dr. Rupp: When I made that motion I thought we had won the thing. I think we ought to have this through unanimously and have every member thoroughly convinced on the proposition.

I wish to talk more fully to Dr. Denham and others who are not converted. This is a serious situation. I feel that this is the solution of a problem which is a very great one. We asked Mr. Norton of the Community Fund why the Wayne County Medical Society could not provide for an investigating committee of all these cases. He said there are 80,000 cases and if there was $1 provided for each case that would mean $80,000.

Right here we are providing $100,000 worth of investigation free of charge. It puts the investigating nurse, all the social agencies boosting for the free clinic and the state medicine and the receiving hospitals first on the case, instead of the local physician in the community where they found him.

If the local physician refuses to treat him he can give a statement to the nurse and she can go on with the case to the receiving hospital. That will provide for free medical care and they will get at least one call out of every physician that goes there.

There isn't a physician in Detroit so hard-hearted that he will not appear in an emergency. We are giving $100,000 in calls to them for nothing by this arrangement. We are providing $100,000 worth of investigation for nothing. It is putting the emphasis on the doctor's office as a health unit for that community. We are entitled to a bit of advertising and we will get it rightly through the work that we do in our own offices, charity work. Any charity you do in the free dispensaries boosts that community outfit, and not you.

I talked to the superintendent of the Dodge Community House. I said, "That is a nice bit of advertising the minister of the First Presbyterian gave your wonderfully complete surgical and medical clinic at Hamtramck."

He said, "We have a wonderful outfit. We have the young physicians coming from Harper Hospital and they give us a wonderful service. All of them are ambitious and of course they give wonderful service."

A few months later I ran across a case like this where a woman had been in the clinic. She didn't know who the doctor was who had looked at her throat. She went home and had throat trouble. They had no family physician. They didn't know who to call. They brought her down to the hospital that I am connected with and we found a case of severe diphtheria.

Had that family been trained by the social worker to have a family physician look after them a more adequate service would have been rendered. That had been an undiagnosed case for two or three days.

I am emphasizing the importance of the

best public health that can be given only to the public if they are tied up with the family health adviser and if they are tied up with them in their own community. The old-time family physician is the one we ought to emphasize. With all due regard and respect to the men doing the work in the free clinics, as I mentioned, it is not always fair to the others in the profession.

The Health Director of Hamtramck wrote a letter to the doctors asking them what they wanted and if they wanted a free clinic and every one of them cursed him. He told the Wayne County Society that it reflected the real attitude. It is not fair to the men in Hamtramck that the men from Harper Hospital should go over there.

A large number of the cases should be investigated by the physician and he should decide whether they are entitled to free aid or not. I think that is a very important thing. I think this will bring back the emphasis of the family physician as it should be.

Dr. Baumgarten: Dr. Rupp mentioned one instance of the Dodge clinic which received some very valuable publicity from one of the pulpits of our city a short time ago.

I hold in my hand a schedule which is posted around by the Dodge Clinic. Understand this is not for free patients, but this is what they advertise to their workers and anybody who wants to come.

Each visit is 25c, tonsilectomies $5 to $15, circumcision $5 to $15, operations at Harper Hospital are $3.50 per day, pre-natal cases, home cases, pre-natal care and instructions are given by a visiting nurse of the Visiting Nurses' Association and they are attended at home by the staff physician and there is a delivery nurse at delivery. That is at the home. Hospital cases at Harper Hospital, attended by the staff physician, are priced at $5. Exceptions are made to all free cases. That is printed at the bottom of it. Those prices are for the paid cases.

Dr. Rupp: I spoke to one of the ministers who is in charge of a community house and I asked him what he thought of the proposition.

He simply said, "You doctors are a bunch of fools. Don't you know and realize that the free clinics in your hospitals are drawing the practice away from your private office?" The layman can see that, why can't we?

Dr. Ellet: I would like to know if this situation exists outside of Wayne County? It seems to me that we are asking the House of Delegates to wash the dirty linen for Wayne County. Maybe I am wrong in that. If I am I will be glad to be set right.

I interned in Wayne County. I know what the work there is and what the chances are for a young doctor in Detroit. I got out of there and went into the sticks. It seems to me that the other cities that have had this proposition, like Grand Rapids or Flint, should say something, we should listen to them and find out what the situation is. I do not believe this exists all over, or at all in the smaller towns.

I do not think the House of Delegates should consider this. I think it should be referred back to the Wayne County Medical Society.

Dr. Marsh: I think the gentleman who just sat down hit the right idea. I would say that when it comes time for the Michigan State Medical Society to go into Wayne County and help them out of their difficulties that we have come to a pretty fine state of affairs.

I did the same thing as this other gentleman did, I got through going to school in Detroit and then I went out into the sticks. I do not make much money but I have a lot of fun. We do not have trouble with free clinics.

I would advise any of the gentlemen from Wayne County who think they cannot make enough money there and have to take care of too many free patients that they should come into the small towns. That is where life is worth living and you do not have troubles with free clinics.

This is a question for Wayne County to decide for themselves. It seems to me that we are taking up a lot of valuable time that we might be using for more profit otherwise. (Applause)

Dr. W. E. Barstow (Gratiot-Isabella-Clare): I hear these fellows talking about being out in the sticks and not coming up against this thing. I live out in the sticks too. I live in a little town of 3,000 or 4,000 and we are near a town of 7,000 or 8,000.

Right in our community we had a school nurse who was advertising to every child that she found in the schools, "Go to Dr. So-and-So and he will do this for you for $5."

There was no question at all as to whether that doctor was able to do that

or not, and whether the patient was able to pay. We found out that a doctor was taking out tonsils for $5 from the farmers who owned 200 or 300 acres of land. That happened in Gratiot County.

Of course, it isn't as prevalent as it is in the city of Detroit. I grant you that. We haven't the general free clinic but we do have the same question popping up in the little communities that you have in the big cities.

I think this is really a question for the State Society to pass on. It doesn't hurt the State Society to help Detroit clean their linen because I think all of us get a little of our own mixed in with it occasionally. (Applause)

Dr. Dutchess: I should like to point out that this afternoon a very generous consideration was given a problem that I believe was in South Haven. I am heartily in favor of that consideration.

I might point out what doesn't appear to be generally known, that the membership in Wayne County is almost half that of the State Society. I rather resent the implication that it is not the business of the State Society to assist in any concern of the Wayne County Society.

Dr. Henderson: I would ask the Speaker to ask some other gentlemen or delegates living in Grand Rapids, Lansing, Kalamazoo and a few of the other towns what they have to say about this. I have heard some remarks out in the anteroom and from them I think they have the same thing to contend with. If the shoe fits you, wear it. I do not like the remarks about Wayne's dirty linens being washed because we do not do it for Wayne alone.

Dr. Denham: We do have the same difficulties but we tackle them from a different angle. We tackle them through the staff of our hospital where our free clinics are located. We have one in hand right now which is being attacked by the staff members of that hospital. It strikes me that that is the proper way to approach it.

Dr. Andrews: I wish to concur with the men from Wayne County in the fact that the clinics are raising particular hob in our community. We have had a bit of a fight in the last year in Kalamazoo and we have spent something like three months attempting to arrive at a solution of this problem.

I happen to be chairman of the committee and we finally came upon the solution of the classification of every individual who applied at the clinic for aid in any way, shape or manner. I feel that Wayne county does deserve some consideration in this matter.

Dr. Himmelhoch: If you will indulge with me to the extent of a few words, I think that Wayne is entitled to resent the attitude of the gentlemen who ask the various members of the Wayne delegation to go out into the sticks. I have no argument with anybody wishing to practice in the country, nor have I any argument with the individual who wishes to practice in the city. On the other hand, let that gentleman think of how quickly he would come to the State Medical Society with a problem that affected him in his local community of about 45 doctors in the county or any one of the 45 doctors there. I am perfectly certain he would come, as he is entitled to come, and just as the gentleman from South Haven came, to the delegates of the State Medical Society for help in his solution of the problem.

When he speaks so heatedly against the request of some members of Wayne County who come with a very serious problem to the House of Delegates he is being just a bit unfair. Wayne County gives his group and like groups a great deal more consideration than they are willing to give us.

Dr. Baumgarten: I do not believe the delegation from Wayne wants to be misunderstood in this matter. They do not want to have the House of Delegates go on record that every man should make a mistake, or should he make a mistake is going to be kicked out.

What it means is that if the House of Delegates here today passes such a resolution and if that is given a certain amount of publicity we can use that very same thing as a club in Wayne County to help get rid of our dirty linen. That is what we are after.

Dr. Garner: I believe that this evil spreads over every state in the Union. I know that there are certain classes of individuals who make a practice of getting something for nothing no matter how well provided they are with this world's goods. I believe that the medical profession should stand as a solid unit in making an effort to wipe out that class of individual and seeing that they pay for what they get.

In other words, separate them from the worthy ones, the ones that really are needy and need the help. They have these clinics and they are there with money, oftentimes

plenty of it, and they are treated. They make a business of that sort of thing. Those people make a business of going in and getting what they can and getting it for nothing just as much as the thief makes it his business to pick off anything he can get his hands on and get away with.

I believe it is up to us to stand as a solid unit in wiping out that condition. It will not only help the medical profession but it will help the layman in separating the honest from the dishonest. We are taking a step that will help to improve the honesty of the people in that class and will cut out the dishonest ones creating some means of finding out and separating them from the free clinics. I think we will have done an awfully good thing not only for the medical profession but for the layman.

Dr. Allen: I cannot see how a resolution from the House of Delegates is going to help these men materially with their problem in Wayne County. I have often wondered why any doctor should donate his time. The grocery man doesn't donate his groceries to poor patients for nothing. The county has general taxation.

Our problem in Bay Cunty is being solved in that way. We are putting the burden on the county and letting their physicians take care of them. That is the way we are handling it there.

You wouldn't have the clinics in Detroit and everywhere else if the men weren't so much in favor of working in them and giving their time. Our clinic was disbanded because the men didn't give their time to the clinic. The thing was pushed over on the taxpayers of the county. That is really where it belongs.

If you can convince me how the resolution is going to help you I am perfectly willing to vote for it.

Dr. Carstens: I think we are all heartily in accord with the spirit behind the motion. I haven't heard anybody talking of having the populace in general treated by the state and for nothing. The discussion has possibly gotten a little bit away from the motion. That is the only thing I would like enlightenment on.

To me it would seem to resolve itself on this, that the decision as to whether the individual is entitled to free treatment is one that should be made by the local physician.

Some social service departments are exceedingly cursory in their investigation of cases. I know we have that problem in Detroit and I know the local public health committee in the past has taken up the matter with certain agencies. It has improved matters very much.

That is a point that I confess I am not sure of. If a man comes into my office I know better than these social workers if he is entitled to free treatment or not. I am acquainted with him very well, I have seen much of him and I have had many discussions with him.

I am heartily in accord with everything that has been said against carelessness on the part of the social service individuals. In most institutions I think they try to invetigate the cases thoroughly. Where they do not that is where the difficulty arises.

If an individual comes to my office and leaves his fur coat in the Ford sedan around the corner, then I am not sure whether I am better qualified to judge whether he can pay me than somebody else who visits him in his home and takes down definite data as to his income and so on. I think we are all in accord with the spirit and principle but I am not sure whether the solution is the best one.

Dr. Insley: A year or so ago the investigations of these paid patients was made by nurses finishing their training and taking their social service part of the course. I would hesitate to wonder whether they would be more capable of judging that patient than I am.

If they were trained social workers, all well and good, but a lot of them are not. In that connection it might be interesting to know that it is more or less common gossip that the Receiving Hospital in the city of Detroit has a much closer checkup on the patients than the clinics and they are not on a competitive basis. The other various clinics are more or less on a competitive basis.

Dr. Himmelhoch: I would like to ask Dr. Carstens one question. He is well acquainted with the subject. He is versed with the affairs at Harper Hospital where there is a very elaborate social service investigation. I would like to ask him whether it is the philosophy at Harper to see free patients or paid patients in the hospital, those patients to be attended by physicians without remuneration to the physician.

Dr. Carstens: I really do not know. I do not speak for Harper Hospital. I can tell you this, that Harper Hospital accepts staff patients who pay for their board and

room and receive the care of the staff of the hospital, which I believe is quite general in large hospitals.

Dr. Himmelhoch: Do the patients in the dispensaries pay fees to the hospital? What does Group 1, 2, 3, 4, stand for? Group 1 are the patients who pay fees that run up as high as $15.

Group 2 are the patients who pay fees that are less than that.

Group 3 are something like 25c apiece and Group 4 is something like 50c apiece. They have urinalysis and blood counts and the patients complain that they do not want to come so often because they have to pay out $2 or $3 every time they come to the dispensary.

It is the theory of the social service that Group 4 should be eliminated. They are doing their best to eliminate any free work in the clinic. What the Wayne County group is trying to get as, if each individual has to act as an individual in combatting the social service organization they are perfectly helpless. If they get the backing of the State Medical Society —and incidentally get the backing of the County Society—they will be in a much better position to act.

The staff members are perfectly helpless at present unless they want to lose all the opportunities of hospitalizing their patients. They are in the position of taking what the social worker orders or leaving the hospital. But if the entire staff says that it is the sense of the State Medical Society—and incidentally the penalty in our County Medical Society is expulsion if you do it—and all the free clinics are faced with losing the entire medical staff, that will set them to thinking as to some solution of the problem. We are perfectly helpless unless we get that.

Dr. Southwick: I believe the majority of the delegates here are heartily in sympathy with the clinic problem as it is before the doctors today.

As far as doing a preponderance of free clinical work, I think most of us do our share. There is no profession that does it as much as the physician, with as little pay. I think some of the delegates from Wayne County have the wrong impression with regard to the rest of the members of the state. We are in sympathy with what they are up against. From my own point of view I believe this problem should be settled in each separate county.

I do not believe any group of delegates from Detroit, or the delegates from the entire state, can set up a rule here that will be swallowed by the Board of Trustees of any hospital in the city of Detroit or throughout the state. We must remember that these hospitals are largely put up by public subscription, they are managed, in the majority of instances, by a Board of Trustees, the membership of which gives large amounts to the hospital and feels they should have something to do with the running of the hospital or with dictating the policy of the clinic.

It would be very nice for the profession if we could eliminate all the laymen from dictating the policies of the profession. Unfortunately, it has gradually gained ground year after year and the clinics have been enlarged until now it is going to take something more than a mere resolution of the assembled delegates of the Michigan State Medical Society to turn the clinics all out and put it either on a strictly charity basis handled entirely by the county or the city physician, or a paid basis going to your private office.

. . . The question was called for. . . .

Speaker Pyle: Is there any further discussion? You have heard the motion.

Dr. Baumgarten: In throwing this open again for a discussion does that mean that this motion must be in order or the thing is automatically dropped, or if another motion is not made this matter stands as it is?

Speaker Pyle: If another motion is not made it stands. We have been discussing the motion but it has been passed.

Dr. Rupp: Does it have to be voted on again?

Speaker Pyle: You moved to reconsider the motion and that was carried.

Dr. Allen: As I remember it, that was a motion to refer to the committee.

Speaker Pyle: It didn't carry.

Secretary: Mr. Speaker, for the information of the presiding officer, as well as the members of the House, the motion to reconsider places the question as the motion made by the doctor from Wayne. It is now a motion before the house. You have discussed it. The House now determines again whether it wishes to adopt this motion or whether it does not.

. . . The motion was put to a vote. The result of the vote was in doubt. . . .

. . . The result of a rising vote was as follows:

Favoring	38
Opposed	6

Speaker Pyle: The motion is carried. (Applause)

Is there any further business to come before us, gentlemen?

Dr. McClintic: I move we adjourn, sine die.

Dr. Baumgarten: I want to thank this delegation on behalf of Wayne County.

Secretary: Mr. Speaker, I think this has been a splendid session of the House of Delegates in which the problems that confront the profession have received just consideration and action by the House.

By the action of the House, through one of its reference committees, each delegate is supposed to go back to the County Society and transmit to it the activity that this state organizaion is engaged in for their individual benefit.

However, during the discussion of this morning, this afternoon and this evening one important feature of our state organizational work has not been touched upon. It is an extremely important feature and one which I feel that the members of this House of Delegates so well represented through the state should receive a little more information upon.

I am suggesting to you, in order that you may carry the information back to your county, that Dr. Tibbals, who for twenty years has been in the medical legal department, tell you of some of its problems in order that you, in turn, may take it back to your members.

Dr. Tibbals is the chairman of the committee. (Applause)

Dr. Tibbals: Gentlemen, I dropped in here because it was a very pleasant way of spending an evening. I had no expectation of doing more than being a listener. I haven't any special desire to say anything to you that you can take back to your county societies other than this, that we feel we are actively working at all times in your interest. We know that for the last twenty years something more than one per cent of the membership of the State Society have been sued annually, or threatened with suit, for civil malpractice. We know, from our experience of twenty years, that no man, whether he be highbrow or lowbrow, is ever safe from this menace. It is not the jayhawker doctor, the man whom you might all say is liable to make mistakes, but it is the good man as well. The menace is on all of us at all times.

We feel that we have an active and a strong organization working in your defense. My personal feeling is that the defense offered the men in Michigan is the strongest possible defense because we have had twenty years of experience in medical legal work, and our general attorney, Mr. Barber, has had twenty-five years experience in this work. He knows the law on this better, in my opinion, than the average trial lawyer.

The thing for you to do, of course, and a lot of you have done it years ago, is to supplement the protection offered by the State Society by an insurance policy. The insurance company, working with your Medical Legal Committee, will offer you the strongest possible defense.

The reason you should all carry an insurance policy is that the State Society only defends you. They will carry you without expense to yourself through every Michigan court but in the event that you have been careless and that a jury has rendered an adverse verdict in the lower court, and the Supreme Court, on legal grounds, has not reversed it, then you are confronted with the necessity of digging down into your own "jeans" and paying that verdict. It is a very sweet thing if your house burns down to feel that you are fully insured. It is a very sweet thing if you have a judgment finally rendered against you to have an insurance company that has to put up the money to pay the judgment.

I think that is all I want to say! (Applause)

Secretary: Mr. Speaker, the Jackson County Medical Society has a thoroughly competent Secretary who has an all-enduring power. He has a brother-in-law by the name of O'Meara, Riley is the Secretary and O'Meara is his brother-in-law. I want to have O'Meara extend you an invitation from the pair. (Applause)

. . . Invitation to a luncheon extended by Dr. O'Meara. . . . (Applause)

Speaker Pyle: Before adjourning I would like to invite suggestions from you during the year. For instance, this is a big state and it believes in organized medicine. I have to appoint men to different committees. You men in your County Societies know who the workers are, men who will make good chairmen and members of committees. That doesn't mean that Dr. Jones might write that he wants so-and-so appointed and that he will be appointed because I cannot appoint every one of you. But, I would be glad if dur-

ing the year you would send me correspondence to that effect so I may know where there is good timber for committees.

Is there any other business to come before us?

Dr. Henderson: I move we adjourn.

. . . The motion was seconded and carried. . . .

. . . The meeting adjourned at nine-twenty o'clock. . . .

F. C. WARNSHUIS,
Secretary.

WOMAN'S AUXILIARY

Having celebrated our third birthday together at Jackson, in September, we are becoming better acquainted and feeling more like the happy family that we should.

Under Mrs. Kiefer's very able guidance the society has been so well organized that the work before us now is principally one of development. At present the following counties are organized: Barry, Bay, Calhoun, Jackson, Kalamazoo and Wayne. With members of the State Medical Society in nearly every county we should have many more actively interested women in the Auxiliary.

As you know the object of the society is "to extend the aims of the medical profession, through the wives of doctors to other organizations which look to the advancement of health and education. To assist in entertaining at all Michigan State Medical Conventions, to promote acquaintanceship among doctors' families that closer fellowship may exist and to do such work as may be assigned from time to time, by the Medical Society."

With dues of the State and County put purposely low so no one need be excluded and membership only limited by your husband's interest in his society, no doctor's wife should feel that she could not become a member. We would like to have each county take for its responsibility to organize, an adjacent county. Look at your map of Michigan; write or see your unorganized neighbor, plan a meeting with them, write your State Secretary, Mrs. J. E. McIntyre, of Lansing for a copy of the State constitution and by-laws and with very little formality a new society can be organized. Your State President also is ready to do all in her power to assist in organizing or helping in other ways.

Our main idea is acquaintance with one another, with the thought, that through our common interest, we may become good friends. In our work together it is our hope that we may be able to give to our husbands just a little more intelligent co-operation and interest in their work which is a very important one in this world of ours.

Very cordially yours,

Mrs. L. J. Harris,
State President.

MINUTES

The Third Annual Meeting of the Woman's Auxiliary to the Michigan State Medical Society was called to order at Jackson, Michigan, September 18, by the president, Mrs. Guy L. Kiefer.

Mrs. John Smith, of Jackson, extended a very cordial greeting to the guests numbering 110, and then introduced Mrs. Blackerby of Louisville, Ky., who is president of the Southern States Woman's Auxiliary. Mrs. Blackerby brought Kentucky greetings to Michigan and then went on to explain some of their aims and activities. There are 400 members in the Louisville Auxiliary. They are putting on a study course to familiarize themselves with state laws so they may be an aid to medical circles in every way. Some members have given health talks over the radio. One rural county has put Hygeia in every school in the county. Some counties are doing hospital work, some are working in day nurseries. In Louisville the auxiliary has furnished flowers to the hospitals, donated by various members. They have given parties for crippled children, have collected Sunday School papers, "funnies" and other papers and brought them to these cripplied children. They take space in their State Medical Journal each month so the various auxiliaries may learn of all activities. They are compiling biographies of prominent physicians. The Historian takes care of this and will have this put in book form. They now have more than 200 men written up.

Mrs. Blackerby was a most charming woman and delightful speaker. She stayed just until her talk was given and then started on her long drive home, which would keep her on the road all night, but she was anxious that Michigan, a younger auxiliary, should hear what can and is being accomplished.

Mrs. Smith then introduced Dr. Arthur McCormack, secretary of the State Board of Health of Kentucky, who gave a very interesting talk of five minutes. Dr. McCormack and his father before him, also the secretary of the State Board of Health of Kentucky, are the only two men to hold that position in Kentucky. Dr. McCormack in his remarks said that the fine modern woman of today cannot be contented without rendering service to humanity. The best person to give information on health subjects to the various clubs is the wife of a doctor. Dr. McCormack said our important work lies in the rural communities. No civilization has lasted by building up of municipalities to the detriment of rural communities. We could not have built our fine roads, our universities, etc., if we had not put under control, for the country peoples as well as the city, tuberculosis, typhoid and other diseases. When our rural population becomes dissatisfied and will no longer be contented outside of cities, and we are fed by another country, before many centuries have passed we will belong to that foreign power.

Dr. McCormack mentioned the fine work done by Caroline Bartlett Crane in Kentucky 20 years ago improving sanitary conditions. They feel a very deep sense of gratitude in Kentucky toward Mrs. Crane.

In closing Dr. McCormack said we must realize our duty to civilization as wives of the grandest profession on earth. We should feel not only pride in what our forbears have done, but what our descendants may do, if we build our auxiliary wisely and well. The women of today have tremendous power and let us remember to use it well.

The guests were then entertained with two harp selections by Miss Lucille Brogan, daughter of a Jackson physician.

Mrs. Genevieve Dunn Smith then delighted the

audience with a vocal solo which was beautifully rendered.

Mrs. John Smith in a very charming way turned the meeting over to President Kiefer for the business session. Mrs. Kiefer in a few remarks complimented the Jackson ladies on the perfect organization they had formed and thanked them in behalf of all guests for their wonderful hospitality and their good fellowship.

The Secretary's minutes of the previous meeting were then read and accepted.

Reports of delegates from various counties were then read.

A representative from Berrien County then extended a very cordial invitation to meet there next year.

The treasurer's report showing the following was then read and accepted.

BAY COUNTY:

National dues	$14.75
State dues	20.25
Total	$35.00

CALHOUN COUNTY:

National dues	$ 8.50

BARRY COUNTY:

National dues	$ 2.00

INGHAM COUNTY:

National dues	$11.75
State dues	35.25
Total	$47.00

JACKSON COUNTY:

National dues	$13.50
State dues	40.50
Total	$54.00

KALAMAZOO COUNTY:

National dues	$21.00
State dues	44.75
Total	$65.75

SAGINAW COUNTY:

National dues	$11.00
State dues	33.00
Total	$44.00

WAYNE COUNTY:

National dues	$67.25

Check for $114.50 was mailed the National treasurer, leaving a balance of $20.25 National dues on hand and $173.75 State dues on hand.

A motion was then made that the rules be suspended and the by-laws be amended to make the immediate past president a member of the Executive Board for one year. M. S. C.

Mrs. Conley of Detroit made a motion that the expenses of the Executive Committee attending meetings called by the president be paid out of the State funds. M. S. C.

A motion was made that bills amounting to $23.75 be allowed Jackson County for the Annual Meeting. M. S. C.

The report of the nominating committee was then given by Mrs. Grant of Kalamazoo.

Mrs. L. J. Harris of Jackson for president.

Mrs. Hugo Freund, Detroit, vice-president.

It was moved that all rules be suspended and the secretary instructed to cast a vote for the above. M. S. C.

Vote was cast.

A few remarks were made by President-elect Mrs. Harris, who took the chair while President Kiefer gave her address, which will be found below.

It was moved by Mrs. Smith of Jackson that a copy of Mrs. Kiefer's address be sent to all county auxiliaries.

Mrs. Kiefer then called on Mrs. Crane for a few remarks, which were very well received. Mrs. Crane urged that we do more for our rural population, who are not up to par in health matters. We do not know the wives of our country physicians as we should. Why not make the effort to have some of our auxiliary meetings in the rural districts? No special program should be advocated, but do what we find to do at our own door. This is a very human organization if we will only make it so. Let this be our motto: "Do the next thing."

Mrs. Kiefer then introduced Mrs. Louis Hirschman, wife of the president of the Michigan State Medical Society, and Mrs. Barnes, wife of Dr. Barnes of the Rockefeller Foundation.

The meeting was then adjourned.

The Jackson ladies are to be complimented on the splendid entertainment given visitors. Every thing was done for their pleasure and comfort.

There were hostesses at the Hayes Hotel at all times to assist any one in need of help.

One day was given over to a trip through the new state prison, with luncheon served there.

Tea was served on the mezzanine floor of the Hayes Hotel on Thursday. The table was beautiful with flowers and candles; and during tea the guests were entertained with delightful vocal solos. Mrs. E. L. Peterson presided at the table.

The visitors all voted the Jackson auxiliary perfect hostesses and hoped they might sometime have an opportunity to repay their unfailing courtesy and kindness during the meeting.

Mrs. McIntyre, secretary-treasurer, will welcome any items of interest to the auxiliaries and will see that they appear on the Woman's page in the Journal. Won't each auxiliary try to mail something in each month?

PRESIDENT'S ADDRESS

Members of the Auxiliary:

Today's meeting marks the end of a two year period of existence of the Michigan State Auxiliary. This period has been largely one of organization. Your officers have exerted all their efforts along this line. During the first year county organizations were formed. Members of your executive committee and your President and Secretary visited a number of cities in the state in an attempt to add to the existing Auxiliaries. In some cases their efforts met with success, and the number of branch Societies grew somewhat the second year. However, there have been instances where your officers were unable to interest the local women. Therefore, no Auxiliaries have been formed in such places much to our regret. Accordingly, there still remains much work of organization for the incoming officers.

At the close of the last year your President made several recommendations. These recommendations met with some favorable comment but the work done for the carrying out of the same

does not seem to have been considerable. During the 1929 Legislature the doctors of the state were much interested in the passage of a so-called Qualifications Act. The principle requirements were that all candidates, who were desirous of taking a course to permit them to practice the healing art in any way whatsoever, should first meet certain educational requirements. The second bill that the doctors are interested in embodied certain amendments to the present Medical Registration Act. Both of these bills were defeated, largely due to the fact that they had not sufficient backing from the profession at large and from the Auxiliaries. The work of passing them was left to a comparatively small committee while the opposition, consisting largely of osteopaths, chiropractors, and other cultists, was well organized and represented by large numbers. It was by veto of the Governor that the chiropractic and osteopathic bills were defeated.

My reasons for rehearsing these facts to you at this time is to remind you that a similar state of affairs will present itself in the Legislature of 1931.

Undoubtedly the members of the State Medical Society will have legislation to present in 1931 which the women of the Auxiliaries should support. As soon as such legislation has been formulated the State Auxiliary should get busy and begin systematic work looking to the passage of the proposed laws.

At the last annual meeting much interest was shown by the membership in the establishment of county health units in the State of Michigan. There are now four such units in existence. These are in Oakland, Saginaw, Wexford and Genessee Counties. The Legislature of 1929 added our amendment to the law allowing an appreciation of $30,000 to be given by the state to counties in which county health units are established, provided, however, that not more than $3,000 shall be allowed to any one county. The State Department of Health is making every effort to have the number of health units increased but they are not asking the establishment of a county health unit in any county unless the place has first been endorsed by a County Medical Society. The week of October seventh is the time when meetings are held by various County Boards of Supervisors at which appropriations are allowed. The State Department of Health expects that a number of boards will allow appropriations this coming month, but there can be no doubt that additional pressure at this time would help the cause along. Without desiring to make any recommendation along this line I would suggest that the officers of the various County Auxiliaries and the incoming officers of the State Auxiliary can, if they are interested, acquaint themselves with the situation by getting in touch with the State Department of Health, through the Deputy State Health Commissioner, Dr. Don Griswold.

In this brief report I have purposely refrained from making any definite recommendations. I wish to express my thanks to the Secretary, who has been faithful to her duties at all times, and to thank the members of the Executive Committee for their co-operation. I wish the Auxiliary continued success.

DRIED HOG STOMACH NEW CHEAPER ANEMIA REMEDY

Dried stomachs of hogs are soon to vie with livers as the saviors of sufferers from pernicious anemia. This newest anemia remedy, made from one of the few unused parts of hogs, has just been developed and announced by Drs. Cyrus C. Sturgis and Raphael Isaacs of the Simpson Memorial Institute for Medical Research of the University of Michigan and Dr. Elwood A. Sharp of the Department of Experimental Medicine of Parke, Davis and Co.

An ounce of extract from the dried, ground stomachs of hogs is as effective a remedy in pernicious anemia as a half pound of raw liver or the amount of liver extract derived from this amount.

This is the latest step in the conquest of a disease, pernicious anemia, which a few years ago was in the category of the unvanquished ills of mankind. In 1926 it was found that by feeding liver to anemia patients their red blood corpuscles could be increased. Liver, once the poor man's meat, increased in price rapidly. Then the active principle in liver was extracted so that anemia patients could take small doses of the extract instead of eating large quantities of the liver itself. Now comes the new and cheaper source of the anti-anemia principle.

The new extract from hog stomach is not yet commercially available. But it should be far cheaper than liver or the costly liver extracts on which pernicious anemia patients until now have been dependent. Hogs' stomachs are largely a waste product, finding only slight use in the production of pepsin. The dried extract is practically tasteless and looks something like sawdust particles. Beef stomach and ox stomach are sold as tripe, which is a familiar food to many. Hog stomach, which has a different structure, is ground and dried to make the new extract.

An immediate increase in the number of red blood cells took place when this dried hog's stomach was fed to patients suffering from pernicious anemia. The increase was even greater than that following liver treatment.

The new remedy for pernicious anemia, dried hog's stomach, was partly inspired by the work of Dr. W. B. Castle of the Harvard Medical School and the Thorndyke Memorial Laboratory of Boston. In pernicious anemia the red blood cells fail to mature properly. Dr. Castle demonstrated that the stomach of normal persons secretes a substance which could develop a blood-maturing principle from meat. Consideration of this led to test the effect of stomach tissue itself. Working on much the same theory, Dr. Elwood A. Sharp of the Department of Experimental Medicine, Parke, Davis and Co., arrived at a similar decision. The three scientists then developed the new remedy together. Dr. Sharp believes it likely that liver or liver extracts supply an essential substance which is easily formed from ordinary food in the normal stomach but which is imperfectly or scantily formed in the abnormal type of stomach found in the patient suffering from pernicious anemia.

The search for this essential substance is now engaging the attention of the three scientists.—Science Service.

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NOVEMBER, 1929

"I hold every man a debtor to his profession, from the which as men of course do seek to receive countenance and profit, so ought they of duty to endeavor themselves, by way of amends, to be a help and ornament thereunto."

—Francis Bacon.

EDITORIAL

PAEDIATRIC CLINIC

A few months ago announcement was made of a fund set apart by Senator Couzens for the betterment of conditions surrounding childhood life in this state. The purpose of the fund was stated sufficiently broadly so as to include almost any movement that had for its object child welfare. The state of Michigan has been divided into three centers based on a survey of the various conditions affecting adversely the health of children and an effort will be made to increase knowledge pertaining to health and child welfare about these centers. Concerning these we hope to go more into detail in future numbers of the Journal.

The immediate subject, however, is the Paediatric Clinic to be given under the auspices of the Department of Post-Graduate Medicine at Ann Arbor on Tuesday, November 26th. This Paediatric Clinic is made possible through the munificence of the Couzens fund. A splendid program is being presented, the details of which appear elsewhere in this number of the Journal. Beginning at ten o'clock, there will be a busy as well as profitable day. The subjects are such as to have a great appeal to men in general practice. There is also much of interest for the paediatrician. The personnel is of a very high order, each one an authority in his subject.

PRESIDENT RUTHVEN

The action of the Board of Regents of the University of Michigan in the selection of a President at this time is to be commended. That the position is a difficult one to fill no one doubts. An indefinite postponement, however, is not the best thing for the University; it means more or less doubt and indecision in regard to its policies. The position of University President demands rare qualities of wisdom and executive ability in a comparatively young person inasmuch as the physical demands of the office are too great to be undertaken by a man who is well into the sixth decade of life.

President Ruthven has the advantage of having grown up, so to speak, in the University. He has had ample opportunity to know its needs and his enthusiasm for its success is that of an alumnus. The appointment of an able head to the State University is a matter which concerns every physician in the state, owing to the fact that the University is a teaching institution for both under-graduate and graduate medicine. Chiefly does its future concern us since the organization of the Department of Post-Graduate Medicine which though really in its incipient years has shown great promise. President Ruthven has the best wishes of the medical profession of this state.

MORTALITY FROM ACCIDENTS

Dr. Louis I. Dublin of the Metropolitan Life Insurance Company presented some interesting statistics before the National Safety Congress which met in Chicago late in September. The United States heads the list of all important countries in the matter of fatal accidents. England and Wales for 1927 had 38 accidental deaths per 100,000 population; Scotland 50 per 100,000; Sweden 35 per 100,000; France 29 per 100,000 and Germany 36 per 100,000, while the United States had 78 per 100,000 popula-

tion. The number of fatal accidents in this country is perceptively increasing inasmuch as in 1928 there were more than had been reported for any previous year. Automobile accidents head the list being responsible for almost a third of the entire number. In 1898 27,500 deaths were recorded from motor vehicle accidents alone. During the same year 950,000 serious though non-fatal injuries were reported. Automobile accidents are more frequent in the rural districts than in the cities.

These statistics present a wholesome object lesson. The solution to the problem of diminishing the number of serious accidents is difficult and far-reaching. Probably the poor showing in the United States as contrasted with European countries is due to the fact of greater speed and haste in this country than in Europe. A partial remedy then would consist in slowing-up the pace with which Americans travel. There is an old proverb to the effect that one should proceed slowly because he has no time to lose. Accidents happen when one is forced or forces himself beyond his maximum of safety.

The problem of driving an automobile involves psychological factors such, for instance, as that of mental control, the ability to estimate distance with accuracy, and the degree of caution. Many who drive automobiles have the mentality and irresponsibility of a child. One method at least of diminishing the number of accidents involves greater care on the part of the tribunal issuing drivers' licenses. Accidents could also be prevented by requiring drivers of automobiles to be adequately insured, so as to take care of any damage they might cause. Inability, financial or physical, to obtain such insurance should of course disqualify the would-be driver.

Another source of danger is the occasional running of an automobile engine in a closed garage. In spite of repeated warnings there are those who will take chances too frequently with disastrous results to themselves.

M. D.'S IN EMBRYO

As the college year opens, over 6,000 students, carefully selected on the basis of college and high school ratings as well as upon various personal characteristics, begin work in seventy-five medical schools in this country. Two-thirds of the number begin their medical studies with college degrees. These young men and women spend their days in laboratories and lecture rooms; their evenings are, or at least should be devoted to their textbooks. They live in an atmosphere saturated with medical terminology. They write from five to twenty examinations a year. Their chance conversations at dinner table or during the leisure hours of the week-end will be devoted to discussing this or that interesting case, or the uncanny insight of some diagnostician, or some difficult operation performed before them. The routine will be broken only during the summer recess when many of the students will attend further courses or do minor work about some hospital. In this way their four years are passed. They will be in contact, however, with many of the leading minds of the profession.

They will, if successful, obtain their medical degrees. Ninety-five per cent of them will spend a year interning in the hospitals; many will remain two or three years. Some will spend additional time in the graduate medical school. Finally this group of students will try to make practical use of their training. There is one of two alternatives for the majority of these men and women. Some will go to the smaller communities where they must practice medicine without the diagnostic equipment to which they have been accustomed. Those who locate in the smaller communities will achieve independence sooner and will be ministering to a real necessity. Others will go to the cities where the hospital facilities and the opportunities for specialization are adequate but on the whole in the hands of older and more experienced men. They will meet competition and the process of getting started will be prolonged and in many instances discouraging. Many will endeavor to supplement the so-called lean years by a salaried appointment in clinics or in industrial medical departments. It is difficult to advise. Those who work hard and intelligently will meet with a measure of success wherever they locate though with the tendency to medical paternalism, the new graduate will face problems that did not exist for the older generation of physicians.

SURE, WHY NOT?

Dr. F. E. Harrington, Commissioner of Health in Minneapolis, in an address before the American Public Health Association which held its 58th Annual Meeting recently in Minneapolis, urged that medical examinations with credits to count towards graduation be added to the public school curriculum. Educators as well as parents

will object that the school curriculum is already overcrowded and that it would be an imposition to require more work from the already overworked pupils. However, there is nothing quite so important as health education and physical development, nothing that is so intimately connected with the comfort and welfare of individuals. The American people are fast becoming health conscious and are reaching out often grasping at the straws of cultism in their eagerness for something definite on the subject of health. It will take some time to inaugurate a system of health education and it will be a matter for each state to consider. When we consider the millions of dollars annually that are spent on patent medicines, healing cults and quacks to no purpose, it is time that something were done to supply this legitimate demand for knowledge on the part of the people, and we know of no better way than to adopt some system of health education in the schools which would be looked upon as the so-called three "R's" are at present. Health education could be presented in such a way as to have a cultural as well as a practical value.

PROGRESSIVE RELAXATION*

There is no other single agent in the therapeutic armamentarium of the physician or surgeon that is more important for the patient than complete rest or relaxation. It is a condition in which the *vis medicatrix naturae* can work to the best possible advantage. In fact nature often compels it even when the physician may have overlooked its importance. The horizontal position places not only less stress upon the heart but is conducive to complete muscular relaxation as well. Rest may be used either alone or as an adjunct to any other method of treatment. Osler was wont to dwell upon the importance of this factor, "the ordinary high pressure business or professional man suffering from angina pectoris may find relief or even a cure in the simple process of slowing the engines." Especially is complete freedom from tension desirable in the management of the nervous element that complicates a large number of diseases . . . . There is a class of patient who is not prostrated or who is not definitely neurotic but who constitutes a problem in fatigue. Such persons are always below par.

The usual prescription for rest consists in putting the patient to bed, or the patient himself takes to bed owing to his inability to remain up. He does not know how to relax, however, and his restlessness may be thereby increased rather than diminished. While confined to bed he shifts about or assumes an uncomfortable position owing to muscular stiffness or rigidity. The so-called rest cure has been associated with the name of Wier Mitchell for nearly half a century. Wier Mitchell, however, did not recognize fully the relaxation factor. He stressed the importance of the elimination of distracting influences and insisted on hyper-nutrition. In fact he was inclined to emphasize the nutritional more than the rest factor in his prescription of rest treatment.

The problem of rest so far as we know has not been approached before from the scientific point of view. Jacobson has investigated the subject by isolating the effects of rest alone, differentiating between rest as a physiologic state and suggestion or other psychotherapeutic measures. The relaxation which he secures is muscular, because of reflex connections, the nervous system cannot be quieted except in conjunction with the muscular system for the whole organism rests as neuromuscular activity lessens. He enters entensively into a discussion of the technic of relaxation which in brief consists of teaching the patient or subject how to completely relax the various sets of muscles until tension is as nearly relieved as possible. It is relaxation by conscious effort or better negative effort. Simple as it may seem it is a matter requiring intelligent co-operation on the part of the patient as well as specialized knowledge, easily acquired, on the part of the physician.

Jacobson has endeavored to prove that muscular relaxation unaided by "suggestion" has an influence upon thinking, emotion and other so-called mental activities. This effect has been studied on the basis of experiments performed in the Psychological Laboratory of the University of Chicago over a period of two years. The nature of this experimentation he has discussed at length in his volume on Progressive Relaxation. To the medical reader his affirmative conclusions are convincing.

This work will well repay serious study by all physicians and surgeons inasmuch as there is no pathological condition which is not mitigated to some extent by complete rest, more so when carried to the point of complete muscular relaxation. The

* Progressive Relaxation—A Physiological and clinical investigation of muscular states and their significance in psychology and medical practice. Edmund Jacobson, A. M., Ph. D., M. D. The Physiological Laboratory, University of Chicago, University of Chicago Press, Chicago, Ill.

problem of rest bears about the same relaxation to general medicine as does dietetics. And no one will deny the importance of properly selected and properly regulated diet. The author has everywhere emphasized the fact that in the general practice of medicine and surgery neuromuscular methods, or relaxation methods, may be used along with diet, drugs, surgery, vaccines, hydrotherapy, electrotherapy and other therapeutic measures.

MICHIGAN'S MEDICAL HISTORY

The task of preparing a history of the medical profession of Michigan from pioneer days has been a colossal one. The committee under the able chairmanship of Dr. C. B. Burr of Flint, Mich., has reported progress to the council of the Michigan State Medical Society from time to time. The history is now practically complete in typewritten form and will be in the hands of the printer within a very short time. The editor has had the opportunity of reading a considerable portion of the copy and can assure the readers that the work is of very high merit. The medical society has been very fortunate in the choice of Dr. Burr as author and editor. The history is written in an attractive style with great emphasis on the intimate personal element. It reads like Cushing's Life of Osler which is admittedly one of the best biographies of the past fifty years. Dr. Burr has made many of the older physicians, who have long passed out of the scene, live again.

The work will be in two volumes. The first volume will be pushed forward and completed as rapidly as consistent with good typographical work. While we cannot publish anything definite at present in regard to the price, we are assured that it will be surprisingly low considering the great merit of the work. The price to the subscriber will be simply the cost of publication as the chairman and his collaborators have given their services without money and without price.

GUARDIANS OF MEDICINE

The better class of lay periodicals, particularly monthly magazines, have published from time to time articles dealing with chiefly the economical phases of medicine. Among the more recent is one in the August number of Current History on "The Cost of Medical Disorganization." Such articles including this are usually by laymen who are inclined to place the whole burden of the cost of medical care on the attendant physician. Commenting on the situation, The Journal of the Tennessee Medical Society goes on to say:

"Such an impression is grossly misleading. One of the authors makes the suggestion that doctors feel that they own the science of medicine. This is not true.

"It may be truthfully said that the science of medicine belongs to humanity and it has been the job of doctors to see to it that no new discovery of value to humanity was monopolized by any individual or group of men anywhere. A medical discovery by a doctor does not belong to him even. It belongs to humanity and medicine has seen to it that the discoverer has no copyright and no patent right on the discovery.

"It may be said that doctors as such are the guardians of the science of medicine and from our observation of what happens with regard to other discoveries and from what has happened throughout all the history of medicine there is no group of men in existence more fitted to be the guardians than doctors.

"The art of medicine is another thing. It is essentially an individual matter. One man acquires an art. He cannot give it away and the practice of medicine is a science and an art. The fact prohibits the practice of medicine from ever becoming what some of our sociologists would attempt to make it."

COINCIDENCE, OR CAUSE AND EFFECT?

Substitution of tea for beer as the national beverage in England has probably been responsible for increased numbers of supersensitive and neurotic people, in the opinion of an English physiologist, Prof. W. E. Dixon. In fact, the growing tendency in civilized countries to substitute tea and coffee for stronger beverages has a bearing on the increased nervous irritability among highly civilized peoples at the present time according to this writer. "England was once a drunken nation. Before the revolution the consumption of beer alone in England and Wales was 90 gallons a head per annum; now it is about a quarter of this. With this diminution of beer drinking is associated a truly enormous increase in tea and coffee drinking." The present comparative sobriety is due in part to the high price of alcoholic liquors. Drinking is an expensive luxury in Great Britain if indulged in to excess.

It is hard to estimate how much nervousness is due to the increased use of tea and coffee. On the other hand excessive over indulgence in beer has its attendant consequences which are much worse. Probably in no other country is the consumption of coffee so great as in the United States. Even in the pre-Volsteadian days most families and in fact all restaurants and hotels served coffee at every meal. Doubtless the custom has tended to produce a nervous citizenry.

THE EDITOR'S EASY CHAIR

OLD ST. BARTHOLOMEW'S

There are localities in London that have an especial appeal to members of the medical profession. Not far west of St. Paul's and about a quarter of a mile north of Fleet Street is old Smithfield, known to history as the scene of martyrdom of more than one hundred men and women, both Catholic and Protestant, who were burned at the stake from the reign of Henry IV to that of Mary Tudor. The Great Fire of 1666,

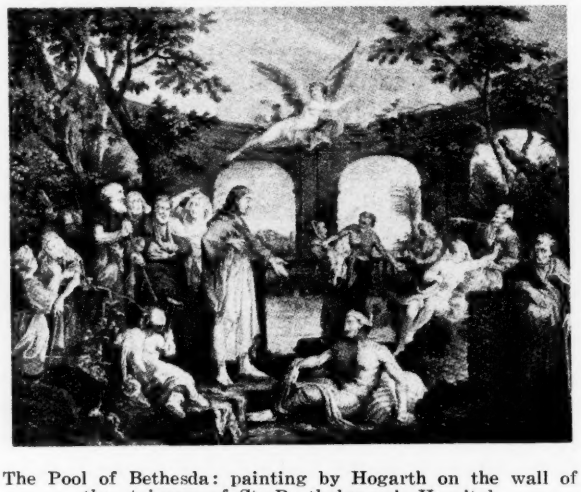
St. Bartholomew's Hospital. The entrance to the old church is seen at the extreme left.

which followed the year of the Plague, stopped just short of Smithfield. It was also the scene of the Peasants' Revolt, or Watt Tyler's Rebellion (1381). The army of discontented peasants was met by the courageous boy King, Richard II, and as a result the assembled malcontents were soon dispersed. Watt Tyler was killed in an unfortunate altercation with the Lord Mayor of London at the time. History gives it this way: "Watt the Tyler mortally wounded but not dead had been carried into St. Bartholomew's Hospital adjoining and Smithfield was still occupied by bands of his men. Walworth (the Mayor) and his followers rode through these hesitant bodies, burst into the hospital, carried out Tyler—whether still living is not clear, and struck off his head."

SERVED SEVENTY-FIVE GENERATIONS

This part of old London contains St. Bartholomew's Church and Hospital. The 800th anniversary of the founding of the church was observed in 1923; the old sanctuary contains the grave of the founder, Rahere, a man of position at the Court of Henry I, who, in gratitude for health restored, founded both the church and hospital at Smithfield, which at the time was just outside of the north wall of the city. The church is so old that the ground around it has risen to such a degree that the approach is a gradual downward slope. The hospital is a parish in itself and contains a small chapel. It is known as St. Bartholomew the Less; the parish in connection with the church is St. Bartholomew the Great.

The hospital, which is located around a huge quadrangle, is known to many physicians of this state, who may have visited it or may have spent time in post-graduate study there. The old hospital rendered service during the Black Death (1348), as well as during the Plague in 1665. It has served twenty-five generations of English people. If the old walls could speak what scenes might they unfold. It is clear that men came here with wounds made by lance and arrow sustained while fighting at Hastings or other battles of remote date, and most recently thousands of the wounded in the Great War were cared for here. In 1555-1557 the smoke of martyrs' fires rose "within a few feet" of its walls, according to a tablet at the northwest corner of the hospital. Both Roundheads and Cavaliers were ministered to side by side in the troubled times of the Stuarts. Throughout the centuries the good work has continued and at no time has the old hospital ministered more effectively than today. In 1552 the hospital contained nearly 100 beds; there are now 687. In-patients, in the middle of the 17th Century, averaged 684 annually. Out-Patients were at that time limited to 50 a week—2,600 in the course of a year. During 1923, 9,214 in-patients were treated in the hospital, while out-patients' attendances registered 342,941. Seven million patients are said to have passed through the gates of "Bart's" during the last 50 years—a mere fraction of the long story of its beneficence.



The Pool of Bethesda: painting by Hogarth on the wall of the staircase of St. Bartholomew's Hospital.

HERE HARVEY WORKED

A year ago the medical world celebrated the 300th anniversary of Harvey's announcement of his discovery of the circulation of the blood. It was in St. Bartholomew's Hospital that Harvey made his experiments, which were destined to form the foundation of modern medicine.

Another event of somewhat less importance was the production of Kirkes' Handbook of Physiology. This book, which was an early text of physiology for many of us, had not only its birth in old St. Bart's, but it had grown to manhood in the same institution. The first edition appeared in 1848; it was based on the lecture notes of Sir James Paget, who taught physiology at the time. Kirkes, the author, who was a student of Sir James, conceived the idea of preserving his master's lectures

* The editor is indebted to Dr. Stanley J. White, Parke Davis company, London, for his courtesy in sponsoring for him and guiding him through St. Bartholomews Hospital. Dr. White is a graduate of the medical college connected with the institution. Also he is indebted for some of the data in this "Easy Chair" sketch to The Story of "Barts" by Herbert Bloye.

in permanent form, so that the first edition was really the work of Paget. Kirkes carried it along for a number of years, revising it in keeping with his own researches; each edition up to the year 1896 was the result of physiological experimentation and studies conducted in the old institution. In 1896 the editorship pased to Haliburton associated with Kings College, London.

Among the great men besides Harvey associated with old St. Bartholomew's was Percival Pott (1714-1788) whose place in medical history is commemorable by at least two pathological conditions the "Pott's Fracture" and Pott's Disease. He was surgeon to St. Bart's (1744 to 1787). It is said that one day he fell and sustained a fracture of the fibula. The enforced leisure turned him to writing and the result was a number of works which were authoratative for the time. Besides the pathologic conditions mentioned we have associated with his name Pott's aneurysm, Pott's curvature and Pott's paralysis. In the museum of the hospital may be seen the vertebrae in which Percival Pott noted the tuberculous condition which he was the first to describe.

Other noted men associated with St. Bartholomew's as benefactors or governors were Thomas a Becket, Thomas Gresham, author of the noted economic theory that "bad money drives out good money"; Richard Whittington, thrice Lord Mayor of London; William Clowes, surgeon to the Fleet that defeated the Spanish Armada; Dr. Caius whose name is associated with Caius College, Cambridge; John Abernethy, one of the greatest medical lecturers ever known of whom it is said that he lost a royal appointment by failing to respond to a call to attend George IV before he finished a lecture. He was a Professor of Medicine at old Bart's. Abernethy was John Hunter's pupil and immediate successor. Hogarth the artist while governor of the hospital painted two large fescoes which still adorn the great staircase to the left of the main entrance—many will recall them —The Pool of Bethesda and the Good Samaritan.

EVOLUTION OF TREATMENT METHODS

The evolution of methods of treatment to be found in the hospital records is not without interest. There were centuries of surgery without anesthetics when the only mode of relaxing the patient was the muscle power of the attendants. It is recorded, however, that chloroform was purchased by the hospital seventeen days after the announcement of the discovery of the anesthetic properties of the drug by Sir James Y. Simpson in November 1847. The hospital pharmacopoeia of 1670 contains a famous "Powder" which was "compounded of serpentary, angelica, crocus, and camphor from the vegetable kingdom, crabs claws and cochineal from the animal kingdom, together with antimony from among minerals." In 1837, the year that Queen Victoria ascended the throne 96,300 leeches were used in the hospital in addition to the wet and dry cuppings to which patients were subjected.

The "cupper" or "bleeder" was the only "specialist" recognized at the hospital before 1867. Now fourteen special departments are busy daily and the equipment is equal to that of any modern hospital in the world. This ancient pile of stone and mortar, for a great deal of it is ancient though succeeding centuries have seen it remodeled and enlarged, is the fruit of nearly a thousand years of civilized life, for there is no greater expression of humanity than a hospital.

NEWS AND ANNOUNCEMENTS

Thereby Forming Historical Records

The A. M. A. will hold its 1930 Annual Session in Detroit, the week of June 22nd.

The Annual Conference of State Secretaries will be held at A. M. A. Headquarters in Chicago on November 15 and 16.

The Joint Committee on Public Health Education will hold its fall meeting in Ann Arbor on Nov. 4th at noon.

The Annual Conference of Secretaries of our County Societies will be held at A. M. A. headquarters in Chicago sometime in January. The exact date will be imparted in December.

During the Jackson meeting someone exchanged overcoats with Dr. R. J. Hutchinson of Grand Rapids. The re-exchange can be made by writing to Dr. Hutchinson.

Dr. George LeFevre of Muskegon, for many years a member and President of the State Board of Registration in Medicine, resigned, and his resignation was accepted by the Governor on October 16.

Dr. J. H. Dempster has taken on as associate Dr. R. W. McGeoch, for the past two years instructor in Roentgenology Medical Department University of Michigan.

Dr. Maxwell, professor of obstetrics and gynecology of the University of Pekin, China, spent two days the guest of Dr. Frank Kelly of Detroit early in October. Dr. Maxwell who has practiced for 31 years in China is at present interested in the subject of spinal anesthesia.

Dr. Walter K. Slack has taken over the practice of his father, Dr. Walter L. Slack of Saginaw upon his father's death. At present he is resident surgeon at the Presbyterian Eye, Ear and Throat Charity Hospital in Baltimore but will return to Saginaw permanently shortly.

Dr. J. R. Carter of the Michigan Department of Health addressed the Berrien County Medical So-

ciety at its July meeting. At the same meeting and due to no small measure to Dr. Carter's efforts the full-time Public Health Unit received a favorable vote.

At the annual meeting of Delta Omega, the honorary public health society, held in Minneapolis on October 2, 1929, during the convention of the American Public Health Association, C. C. Young, Ph. D., Dr. P. H., Director of the Bureau of Laboratories of the Michigan State Department of Health, was elected national president. John A. Ferrell, M. D., Dr. P. H., of the Rockefeller Foundation, New York, was elected national vice-president, and James A. Tobey, Dr. P. H., of New York, was re-elected national secretary-treasurer.

This year for the first time Hurley Hospital, Flint, has a full quota of internes. The Genesee County Medical Society welcomes them and hopes that their stay will be both pleasant and profitable. The names and places of graduation of these physicians are: A. L. Bonathan, K. B. Moore, G. L. Hagelshaw, R. G. White, and M. G. Butler from the University of Michigan; B. F. Sniderman, G. L. Case, M. D. Epstein, A. Cohen, from the University of Toronto; N. Lucius, A. Klomhaus from the University of Illinois; E. Jones, from the University of Kansas, and R. Coldwell, from the University of Wisconsin.

A bi-monthly pathological conference will be a feature of the staff program the coming winter.

Dr. F. C. Warnshuis, secretary of the Michigan State Medical Society, and business manager of this Journal, has been elected secretary of the Michigan State Board of Registration in Medicine to succeed Dr. Guy Connor of Detroit who has tendered his resignation. Dr. Warnshuis is the third person to occupy the position as secretary and Dr. B. D. Harison was the first and occupied the position from the formation of the Board until his death in 1925 when Dr. Guy Connor was appointed. Dr. Warnshuis was at one time a member of the Board of Registration, therefore succeeds Dr. Connor with experience of the duties of the office. The secretaryship does not necessitate the incumbent being a member. It is understood that the office will remain in Detroit where it was removed from Sault Ste. Marie twenty years ago.

The original building of the Detroit College of Medicine, corner of St. Antoine and Mullett streets, was closed on October 2nd by the Mayor of Detroit acting on instructions from the Fire Commission. The building had been considered unsafe from the viewpoint of fire hazard. In the meantime the college sessions for 1929 and 1930 will continue in the new building which was completed three years ago and has since been used as a laboratory building with one floor given over to the Wayne County Medical Library. The action of the Fire Commission was doubtless inspired by a fire that broke out recently in the old premises, 65 Vernor Highway, which were at one time owned and occupied by the Wayne County Medical Society. In this fire twenty-two lives were lost. The Detroit College of Medicine has been a part of the higher educational institutions of the City of Detroit and under the control of the Board of Education for a number of years. In addition to the closing of the medical building three of the public schools of Detroit were closed for a similar reason.

All members of the board of trustees of the Michigan Tuberculosis sanatorium, which was abolished by an act of the last legislature, were appointed by Governor Fred W. Green as members of the commission that will govern the sanitoria of the state. The personnel of the new commission follows: Dr. Ernest J. Browne, of Howell, to serve until October, 1930; Dr. Edwin R. Vander Slice, of Lansing, to serve until October, 1930; Dr. E. J. O'Brien, of Detroit, to serve until October, 1931; Dr. Eugene N. Nesbitt, of Grand Rapids, to serve until October, 1931; Schuyler L. Marshall, of St. Johns, to serve until October, 1932, and Mrs. E. D. Stair, of Detroit, to serve until October, 1932. Under the new law creating the commission, Dr. Guy L. Kiefer, state health commissioner, will be chairman and an ex-officio member.

The following is the preliminary program of the Fourth Annual Clinic of the Highland Park Physicians Club to be held at the Highland Park General Hospital Thursday, December 5, 1929. Dr. Andri Crotti, Columbus, Ohio, Professor of Clinical Surgery, Ohio State University—subject: Goitre; Dr. Paul Titus, Pittsburgh, Pennsylvania, Obstetrician—subject: Problems in Eclampsia; Dr. George Carleton Hale, London, Ontario, Professor of Medicine, University of Western Ontario—subject: Cardio-Vascular Renal Disease; Dr. Jacob Louis Bubis, Cleveland, Ohio, Gynecologist—subject: Pelvic diseases; Dr. Horst Oertel, Montreal, Quebec, Professor of Pathology McGill University—subject to be announced; Dr. Edwin N. Kime, Indianapolis, Indiana, Department of Medicine, University of Indiana—subject: Physio-therapy; Dr. George A. Ramsey, London, Ontario, Professor of Orthopedic Surgery, University of Western Ontario—subject: Bone and Joint Diseases in Children; Dr. Isaac A. Abt, Chicago, Illinois, Professor of Pediatrics, Northwestern University Medical School—subject to be announced; Dr. Chas. Phillip Emerson, Indianapolis, Indiana, Dean and Professor of Medicine, Indiana Medical School—subject: Gastro-Intestinal Diseases.

Address of Welcome, by Mayor Shields.

Address, Dr. J. D. Brook, Grandville, Michigan. President Michigan State Medical Society.

Banquet in evening at Masonic Temple, H. P.

Address, Gus W. Dyer, Vanderbilt University, Nashville, Tennessee. The outstanding orator of the middle west. Subject: Fundamental Americanism.

At the Annual Meeting of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Articles of Association were adopted of what is now known as the American Association of Obstetricians, Gynecol-

ogists and Abdominal Surgeons Foundation Incorporated. The purpose of this auxiliary organization is the promotion and dissemination of theoretical and practical knowledge of the subjects of obstetrics, gynecology and abdominal surgery and their allied branches. There are forty-eight incorporators. The organization was incorporated under the laws of the State of Michigan though meetings of the Board of Directors may be held in either United States or Canada. The immediate activities of the new organization will be devoted to urging better teaching of obstetrics in medical colleges, placing the subject on a par with surgery. An appeal is being made to the Deans of all medical schools stressing the need of this reform. An effort will be made towards making pre-natal care universal. Propaganda will be launched for the better understanding of the importance of maternal welfare among the members of women's clubs, health centers and parent-teachers associations. Three members of the Michigan State Medical Society have been chosen as officers for the ensuing year with the power of conducting business for the next twelve months. They are as follows: President, Dr. G. Van Amber Brown, Detroit; Dr. Alexander M. Campbell, Vice-President, Grand Rapids; Dr. James E. Davis, Secretary, Detroit, Mich.

A very pleasant event took place on the evening of October 2nd at the Beach Grove Country Club, Walkerville, Ontario, under the auspices of the Officers of the Royal Army Medical Corps (British) and the Officers of the Allied Corps, when a dinner was given at which the Colors and Insignia of the Royal Army Medical Corps were presented to Dr. McLean, of Detroit, who while in London, England in May last was made an honorary member of the Royal Army Medical Corps Officers' Mess. There were approximately 250 present representing both medical and civilian population of Detroit, Windsor and Walkerville. Presentation was made by Mr. John A. Cameron the British Consul who is stationed at Detroit. The dinner was preluded by a number of bagpipe selections and by songs by Detroit's noted Scotch baritone, Cameron McLean. Judge Alfred J. Murphy was toastmaster. Appropriate addresses were made by Eccles J. Gott, M. P. Canadian Parliament, Col. H. R. Casgrain who had seen service in the late war on the Island of Lemnos in the Aegean Sea, also by Count Berni-Canani, Italian Consul and Lieut. Col. Rolland Parmeter, representing Base Hospital No. 17, A. E. F.

Mr. Cameron, Consul, in making the presentation of the Colors and Insignia to Dr. Angus McLean referred fittingly to Dr. McLean's services at Dijon, France, when at one time seven hundred British wounded were placed in his charge where many blood transfusions were made from American veins to save the lives of the British soldiers. Of seven hundred only one was lost. The speaker referred to what he termed the distinguished part that Dr. McLean played in the greatest and worst war of history. But all his efforts were to save and not to kill.

Dr. McLean in a brief well worded address recounted his experiences and expressed his appreciation of the honor conferred upon him by the decoration.

A year and a half ago Dr. McLean received a similar honor when the Colors and Insignia of Poland were presented to him by Poland's representative in this state.

DEATHS

Dr. Clarence G. Sayers

Dr. Clarence G. Sayers of Detroit was found dead in his garage early in October. He had received a call about 3 o'clock in the morning and had gone into his garage through a small door, started his machine and then proceeded to open the rear doors of the garage to back out when he was overcome by gas from the exhaust of his automobile. He was found 20 minutes later when life had become extinct. Dr. Sayers was born in Picton, Ontario, 50 years ago. He was educated in the Detroit schools and had graduated from the Detroit College of Medicine in 1904. He is survived by his wife and by two children, Marvin age 15 and Virginia age 13. Dr. Sayers was a member of the Wayne County Medical Society and the Michigan State Medical Society.

Dr. W. M. Weller

Dr. W. M. Weller, a prominent physician of Gratiot County, died August 31, 1929, after more than two years of suffering from arterio sclerosis. He was born in Clinton County, Mich., in 1858, received his early education in the common schools and taught a few years before taking his course in medicine at the University of Michigan which he completed in 1882. His first location was at Pomei, Mich., where he practised for four years. He then took a post-graduate course at Bellevue Hospital, New York and resumed the practice of medicine at Ithaca, Mich., in 1887 where he has since lived. Gratiot County received the whole of his 44 years of professional life. Dr. Weller was one of the organizers of the Gratiot County Medical Society and served as its first Secretary and Treasurer and later as its President. He was also a member of the State Medical Society and a Fellow of the American Medical Association. He leaves a wife and two children, Dr. C. N. Weller of Detroit, Mich., and Mrs. Lewis Reed of Sault Ste. Marie.

Dr. Chester A. Norconk

Dr. Chester A. Norconk of Bear Lake, Michigan, died suddenly September 23rd while attending a patient. Dr. Norconk, who was 75 years old, had practised at Bear Lake for 43 years. He was graduated from the University of Michigan School of Medicine in 1885. Besides the widow he is survived by a son, Dr. Ward H. Norconk, who succeeded him in his practice, and seven brothers.

Dr. W. H. Atterbury

Dr. W. H. Atterbury of Litchfield, Hillsdale County, died of heart disease early in September. He was born March 21, 1870, at Three Rivers, Mich., and came to Litchfield 34 years ago upon his graduation from medical college at the University of Michigan, establishing and maintaining a successful and thriving practice there, except for 19 months which he served with the medical division of the expeditionary forces, part of the time in France, in the World War, from which he emerged with the rank of captain. On February 12, 1902, he was united in marriage to Jennie Hawkins, who with a daughter, Mrs. Milton Magel

of Battle Creek, and two sisters, Mrs. B. F. Askins of Otsego, and Mrs. Robert A. McMullen of Milwaukee, survive him.

COMMUNICATIONS

To the Editor:

The Wexford County Medical Society last fall invited me to present the acid-milk demonstration at one of their meetings. It was quite flattering to note the close attention given my spiel by Dr. Moore, Wexford County's aggressive, full-time health officer. I visioned "buttermilk" being made official fodder at his 25 baby stations, but later incidents suggest that his interest may have been misinterpreted.

At a recent P. G. Conference at Traverse City, he called to me across the table that he had fed "my" (Marriott's) acid-milk formula to one hundred baby *foxes*, with a resultant mortality of none per cent, which he implied was highly unusual. As I confessed ignorance of vulpine nutritional problems, he divulged that let ye infant fox get a bit too much or too strong sweet milk, and he will be found, the morning after, with four feet pointing skyward, swollen up like a poisoned toad. In fact, he said that his skeptical men became so sold on acid-milk that they were quite hysterical whenever the supply of lactic acid threatened extinction.

It is hoped that the doctor may since have found lactic-milk also useful for wee human varmints.

Central Lake, Oct. 15, 1929. Don Duffie.

Dr. F. C. Warnshuis, Secretary:

I wish to inform you that the recent Post-Graduate Conference held at Traverse City on October 11th was a success.

The speakers were all very good and some forty-five physicians attended the Conference and gave their whole time to the program. Dr. Brooks of Detroit, Dr. Hodgen of Grand Rapids, Dr. Schermerhorn of Grand Rapids, and Dr. Griswold of the State Board of Health took part in the program and were all at their best.

I wish to thank you in behalf of the members of the Ninth District for helping to arrange such a satisfactory program and hope that we may have another meeting early in April.

Very respectfully,

Otto L. Ricker, M. D.
Councilor.

September 28, 1929.

Dr. F. C. Warnshuis, Secretary,
Michigan State Medical Society,
1508 G. R. National Bank Building,
Grand Rapids, Michigan.

Dear Dr. Warnshuis:

We received your letter yesterday with official notification of the first prize award at the recent State Meeting in Jackson. The award has been equally divided among the four of us who co-operated in furnishing material for the state exhibit; that is, Dr. H. P. Doub, Dr. John Mateer, Dr. F. Janny Smith, and myself. In behalf of the group and in behalf of the hospital allow me to tell you we appreciate this recognition of our efforts very much and we hope to be able to help you in this line whenever we are called on. Personally, I am convinced that the well arranged, well conducted, and well demonstrated scientific exhibit has as much or more teaching value than the scientific papers which are presented. The teaching value is not alone for the members who visit the exhibit. The exhibitor who stays by his material and demonstrates it learns a great deal, if not as much, as the one to whom he demonstrates.

We would like to tell you also how much we appreciate the interest and co-operation of yourself and Dr. German in our work and the work of other exhibitors. I beg to remain

Very sincerely yours,

F. W. Hartman, Pathologist,
Henry Ford Hospital,
Department of Laboratories.

CAUSE OF CANCER UNKNOWN DESPITE MANY THEORIES

In spite of much research and many theories nothing is yet known of the cause of cancer, if it has a single cause, according to Dr. Shields Warren of the Palmer Memorial Hospital, Boston. "While there is no one accepted cause of cancer, there are certain theories that are useful as working hypotheses," said Dr. Warren.

The reported discoveries, from time to time, of a parasite as a cause of cancer have raised hope. Among these Dr. Warren mentioned the work of Dr. Gye in England which unfortunately was not confirmed.

Many theories that special foods or substances cause cancer have been raised. Civilization has been blamed as a cause of this disease. But all of these theories have proved untenable.

The theory of chronic irritation covers many of the cancers that occur in human beings, but it is to a certain extent a superficial explanation, Dr. Warren declared. Prolonged chronic irritation of tissues stimulates cell growth and brings about unknown changes in the tissues which favor the development of cancer. Many types of chronic irritation do not go on to develop cancer, but many cases of cancer may be traced to long standing irritation.

Heredity has been considered a cause of cancer. Proof of this theory has ranged from examples of so-called cancer families or cancer villages to the painstaking work of Dr. Maude Slye. Dr. Slye proved by very careful and extensive experiments that in mice there is a hereditary predisposition to cancer, but it is questionable as to whether her findings are applicable to human beings, Dr. Warren explained. The so-called cancer villages are usually found to be inhabited largely by older people among whom the prevalence of cancer is always greater, no matter where they live.

"Certainly we are safe in saying that at the present time heredity is not considered of importance as a cause of cancer," Dr. Warren declared. While the cause of cancer is still unknown, enough facts are known about cancer to make its behavior less incomprehensible and its treatment more hopeful.—Science Service.

COUNTY SOCIETY ACTIVITY

Revealing Achievements and Recording Service

Frederick C. Warnshuis, M. D.
Secretary Michigan State Medical Society

The Couzen's Children Fund of Michigan

Presents

A Conference on the Diseases of Infancy and Childhood

Directed by

The University Medical School

and

The Michigan State Medical Society

ANN ARBOR, MICHIGAN — TUESDAY, NOVEMBER 26, 1929
UNIVERSITY HOSPITAL

10:00 A. M. The alimentary tract of infancy and childhood. (Presenting a simple, workable classification of conditions commonly seen, with practical methods of treatment.)

a) Feeding the normal case.
b) Colic.
c) The nervous, irritable, hypertonic infant.
d) Athrepsia or atrophy.
e) Diarrhea.
f) Intoxication.
g) Round table discussion.

—Julius H. Hess, Professor of Pediatrics, College of Medicine, University of Illinois, Chicago.

12:00 M. Demonstration of the teaching of diet to children.
—Frances B. Floore.

12:30 P. M. Luncheon.

1:30 P. M. The practising physician's part in the prevention of contagious diseases of children. Guy L. Kiefer.

2:00 P. M. Physical examination of children with demonstration. David M. Cowie.

2:30 P. M. Treatment of common skin conditions of infancy and childhood. Udo J. Wile.

3:00 P. M. Nephritis, allied conditions, etc.: Simple classifications and treatment. Moses Cooperstock.

3:30 P. M. Gradient idea of Alvarez with special reference to its clinical application to infancy and childhood. David M. Cowie.

4:00 P. M. Demonstration.

a) Sensitization tests.
b) Schick test.
c) Dick test.
d) Blanching test.
e) Coagulation time of blood

—Dr. Cowie and Staff.

POST GRADUATE CONFERENCES

In October Post-Graduate Conferences were held in Traverse City, Benton Harbor, Alpena, Houghton, Marquette and Howell.

Conferences will be held in November in Flint, Battle Creek, Ann Arbor and Jackson. These will terminate the Conference program for this year.

AN ATTRACTIVE PROGRAM

The Pediatric and Infectious Disease Society of the Pediatric Department of the University Medical School presents a program at the University Hospital, Ann Arbor, November 8 and 9, to which the profession is invited.

The program opens at 2:00 o'clock Friday afternoon with a discussion on Meningococcus Meningitis by Dr. Wm. S. O'Donnell and Dr. R. M. Kempton, followed by a discussion of the Rheumatic Syndrome by Dr. S. J. Levin. The afternoon program is concluded by a discussion of The Role of Infusion and Transfusion in the Treatment of Diarrhea by Dr. L. Devil and M. Cooperstock.

The Society extends a cordial invitation to all our members to attend this interesting session.

FRIDAY EVENING

November 8, 1929—7:30 o'clock

Meeting called to order by President.

Reading of minutes.

Election of officers for ensuing year—President, Vice-President, Secretary-Treasurer, Council.

President's Address—Infantile Pulmonary Tuberculosis Due to an Unusual Type of Tubercle Bacilli. Dr. Paul Beaven, Rochester, N. Y.

Present Status of Bacteriophage in the Treatment of Colon Infections of the KUB Tract. Dr. D. Murray Cowie, Ann Arbor.

Bacteriological Aspects of Bacillus Abortus Infections (Undulant Fever) in Man and Animals. Dr. Malcolm Soule, Associate Professor of Bacteriology, University of Michigan, Ann Arbor. By Invitation.

Role of Antibodies in Human Skin Reactions. Dr. Wm. Redfern, Ann Arbor. By Invitation.

Fractional Pollen Antigens in the Treatment of Hay Fever. Dr. Dorman E. Lichty, Ann Arbor. By Invitation.

Observations on Sensitization Patients. Dr. B. Jimenez, Ann Arbor. By Invitation.

Title to be Announced. Dr. Leon DeVel, Grand Rapids.

Meningococcus Meningitis in Lansing, 1929. Dr. F. Sander, Lansinng.

Report of Three Cases of Ulcerative Colitis in Children. Dr. Trevor E. Browne, Battle Creek.

SATURDAY MORNING

November 9- 1929—9:00 o'clock

Unusual Case of Erythema Multiforme, Fatal. Dr. A. Luvern Haye, Ann Arbor, and Dr. Clement Smith, Ann Arbor.

Inhalation of Iodin Vapor in the Treatment of Chronic Laryngitis in Children. Dr. Wm. D. Lyon, Akron, Ohio.

Individual Selection of Formulas in Infants. Dr. Gustave Weinfeld, Chicago.

The Ergosterol Question in Relation to Rickets. Dr. Katharine M. Jarvis, Ann Arbor.

Rate of Immunization with Diphtheria Toxoid. Dr. M. Cooperstock, Ann Arbor; Dr. Gustave Weinfeld, Chicago, and Dr. A. Luvern Hays, Ann Arbor.

Acute Nephritis in Children. Dr. Samuel J. Levin, Detroit. Discussion opened by Dr. Wm. S. O'Donnell.

Filterable Forms of Bacteria. Dr. Phillip Hadley, Associate Professor of Bacteriology, University of Michigan, Ann Arbor. By Invitation.

Evaluation of the Kahn Test in Children. Dr. Gordon Manace, Ann Arbor. Discussion opened by Dr. Reuben L. Kahn.

MICHIGAN STATE MEDICAL SOCIETY POST GRADUATE CONFERENCE HOUGHTON, MICHIGAN — OCT. 30, 1929 HOUGHTON CLUB

PROGRAM

1:30 P. M. End Results of Operations for Carcinoma of the Breast. Richard R. Smith, M. D., Grand Rapids.

2:00 P. M. The Artificial Feeding of Infants. William S. O'Donnell, M. D., Detroit.

2:30 P. M. Recent Therapeutic Advances. Richard M. McKean, M. D., Detroit.

3:00 P. M. General Management of Gynecological Lesions Due to Childbirth. Richard R. Smith, M. D., Grand Rapids.

3:30 P. M. Acute Respiratory Infections. William S. O'Donnell, M. D., Detroit.

4:00 P. M. The Management of the Cardiac Diseases. Richard M. McKean, M. D., Detroit.

This same program was repeated in Marquette.

POST-GRADUATE CONFERENCE — STATE HOSPITAL—TRAVERSE CITY, MICHIGAN FRIDAY, OCTOBER 11, 1929

PROGRAM

8-10 A. M. Goiter Clinic. Clark D. Brooks, M. D., Detroit.

10-11 A. M. Injuries to the Newborn. L. J. Schermerhorn, M. D., Grand Rapids.

11-12 A. M. Meningitis and Diphtheria. Don Griswold, M. D., Lansing.

12 M. Dinner

Hospitalization of the Insane. George F. Inch, M. D., Traverse City.

County Health Unit. Don Griswold, M. D., Lansing.

State Society Activities. O. L. Ricker, M. D., Councilor, Cadillac.

1- 2 P. M. Fractures. J. T. Hodgen, M. D., Grand Rapids.

2- 3 P. M. Causes of Respiratory Difficulty in Infancy and Childhood. L. J. Schermerhorn, M. D., Grand Rapids.

3- 4 P. M. Gall-Bladder—Diagnosis and Treatment. Clark D. Brooks, M. D., Detroit.

4- 5 P. M. Common Orthopedic Measures. J. T. Hodgen, M. D., Grand Rapids.

THE AEREO-MEDICAL ASSOCIATION

The supervision of American air service has been assumed by the U. S. Department of Commerce, which has created a sub-department of aeronautics. This department has two subdivisions: the technical, dealing with the licensing of planes, their inspection, the rules governing flying, airports, etc., and the medical, dealing with the physical standards for pilots and the medical examination of pilots.

The medical division is headed by Dr. L. S. Bauer, who has had a wide and extended experience in this special field. Dr. Bauer has set a high and exacting standard of physical fitness for pilots. No pilot can obtain a license to fly unless he passes this physical examination. Having once passed, the pilot must undergo a re-examination every six months and should a pilot during any re-examination reveal a disqualifying defect he is grounded until the defect is removed. Throughout the country Dr. Bauer has appointed some 800 doctors to whom pilots report for their physical examinations.

Flying is a comparative infant avocation. There are many problems uncovering themselves as experiences broaden. The pilot's physical fitness and physical changes, after several hundred hours of flying, is opening new conditions as to what are disqualifying defects. No standards exist by which conclusions can be reached, for man has never before worked in the air.

Because of these factors and the need of wide observations and study the some 800 medical examiners under Dr. Bauer's leadership felt that an organization, holding one or two meetings a year would centralize their activities and enable them to pool their observations thereby eventually formulating dependable conclusions. In consequence the American Aero-Medical Association was organized in Detroit on October 7 following a three day session that was attended by over a hundred medical examiners from the army and navy. Dr. Bauer was elected the first president and Dr. W. B. Smith of Wethersfield, Conn., was elected Secretary.

"WHAT'S DOING"

You who have failed to keep abreast of your Society progress and activity have an opportunity to learn "what's doing." This issue contains the minutes of our Jackson Annual Meeting. The September Journal contained the committee reports. Take these two issues and read the reports and official minutes. They will impart to you some very pertinent facts.

MICHIGAN STATE BOARD OF REGISTRATION IN MEDICINE

Regular semi-annual meeting held at the Hotel Olds, Lansing, Michigan, at 8 P. M., October 9th, 1929.

PRESENT:

Drs. George L. LeFevre, Frank A. Kelly, Nelson McLaughlin, J. D. Brook, Albertus Nyland, J. Earl McIntyre, W. A. Lemire, W. Ellwood Tew, W. H. Marshall

ABSENT: Dr. Guy L. Connor.

Dr. George L. LeFevre, President, in the Chair.

The meeting was called to order by the President.

Dr. W. Ellwood Tew, of Bessemer, Michigan, submitted his commission from Governor Green, appointing him as a member of the Board of Registration in Medicine.

The President read the following telegram:

"Detroit, Michigan,
October 4th, 1929.

Dr. George L. LeFevre, President.
Michigan State Board of Registration in Medicine, Muskegon, Michigan.

I hereby present my resignation as Secretary of the Board of Registration in Medicine, to take effect Monday, October 7th, 1929.

(Signed) Guy L. Connor."

By Dr. McLaughlin, seconded by Dr. McIntyre:

RESOLVED: That the resignation of Dr. Connor, as Secretary of the Board of Registration in Medicine, be accepted, and a letter of appreciation be sent to Dr. Connor by this Board, in recognition of the valuable services rendered.

Yeas: 9. Nays: 0. Motion carried.

ELECTION OF OFFICERS

By Dr. Brook, seconded by Dr. McLaughlin:

RESOLVED, That the Board proceed to the election of officers for the ensuing term of two years, October, 1929, to October, 1931.

Yeas: 9. Nays: 0. Motion carried.

Upon motion, Dr. Brook in the Chair.

By Dr. Kelly, seconded by Dr. McLaughlin:

RESOLVED, That Dr. George L. LeFevre be nominated President for the ensuing term of two years.

Yeas: 9. Nays: 0. Motion carried.

No other nominations being made, the Chair declared the nomination for President closed.

By Dr. Brook, seconded by Dr. McIntyre:

RESOLVED, That the rules be suspended and that Dr. LeFevre be declared, by vote, President of this Board.

Yeas: 9. Nays: 0. Motion carried.

The Chair announced that the unanimous vote of the members of the Board has been cast for Dr. LeFevre as President.

Upon motion, the President-elect, Dr. LeFevre, in the Chair.

By Dr. Kelly, seconded by Dr. McIntyre:

RESOLVED, That Dr. F. C. Warnshuis be nominated Secretary for the ensuing term of two years.

Yeas: 8. Nays: 0. Motion carried.

No other nominations being made, the rules were suspended and the election of a Secretary postponed for two hours, to permit Dr. Warnshuis to appear at the meeting.

READING OF MINUTES

In the absence of the Secretary, the minutes were read by the President.

No objection being raised, the Chairman declared the minutes of the meeting held in Ann Arbor, June 12th, 1929, adopted as read.

The President announced the following Committees and Examiners for 1929-31:

Dr. George L. LeFevre—Surgery.

Dr. Frank A. Kelly—Obstetrics and Gynecology.

Dr. Nelson McLaughlin—Physiology.

Dr. J. D. Brook—Practice of Medicine.

Dr. Albertus Nyland—Anatomy.

Dr. W. H. Marshall—Pathology.

Dr. J. Earl McIntyre—Bacteriology and Eye, Ear, Nose and Throat.

Dr. W. A. Lemire—Hygiene and Public Health and Medical Jurisprudence.

Dr. W. Ellwood Tew—Chemistry and Toxicology; Histology and Embryology; Materia Medica and Therapeutics.

REGISTRATION AND STANDARD COMMITTEE

Dr. J. D. Brook, Chairman.
Dr. Albertus Nyland.
Dr. Nelson McLaughlin.
Dr. Frank A. Kelly.
Dr. W. H. Marshall.

LEGISLATIVE COMMITTEE

Dr. Frank A. Kelly, Chairman.
Dr. Nelson McLaughlin.
Dr. J. D. Brook.
Dr. J. E. McIntyre.
Dr. W. Ellwood Tew.

EXAMINATION COMMITTEE

Dr. Albertus Nyland, Chairman.
Dr. W. H. Marshall.
Dr. W. A. Lemire.
Dr. J. E. McIntyre.

AUDITING COMMITTEE

Dr. Nelson McLaughlin, Chairman.
Dr. W. A. Lemire.

REPORT OF LEGISLATIVE COMMITTEE

The Chairman reported that there were no matters before the Legislative Committee at this time.

REPORT OF THE EXAMINATION COMMITTEE

The Chairman submitted the report of the June, 1929, examination, at Ann Arbor.

REPORT OF THE AUDITING COMMITTEE

Dr. Nelson McLaughlin, Chairman.
Dr. W. A. Lemire.

The Committee reported that the books and accounts had been audited by the Auditor General's Office, and that they had no further report to make at this time, as they had been found correct.

MISCELLANEOUS

Re: Meharry Medical College, Nashville, Tenn.

Dr. J. J. Mullowney, President of the Meharry Medical School, appeared with a personal request that the Board recognize their graduates for indorsement, since the date they had been placed on the "A" list of accredited medica lschools by the American Medical Association.

By Dr. Marshall, seconded by Dr. McLaughlin:

RESOLVED, That graduates of Meharry Medical College be declared eligible for indorsement, provided they fulfill the requerements of the Michigan Medical Practice Act, and have graduated subsequent to January 1st, 1923.

Yeas: 9. Nays: 0. Motion carried.

Re: Traveling expenses of Board members

By Dr. McIntyre, seconded by Dr. Brook:

RESOLVED, That a committee be appointed to interview the Administrative Board relative to the expense accounts of the Board members.

Leas: 7. Nays, 0. Motion carried.

The President appointed Dr. McIntyre and the Secretary as a committee of two to interview the Administrative Board in this connection.

Re: New form of license, or lithographed certificate or registration

By Dr. Brook, seconded by Dr. Tew:

RESOLVED, That a new form of license, or certificate or registration, be adopted by this Board, and that the Secretary be instructed to prepare the same, by and with the advice of the Attorney General; the certificate for framing purposes to be smaller in size, and to contain only the names of the President and Secretary of the Board.

Yeas: 9. Nays: 0. Motion carried.

Re: Complaint from Dr. Van Leuven, Petoskey, Michigan.

By Dr. McLaughlin, seconded by Dr. Brook:

RESOLVED, That the complaint of Dr. Van Leuven, relative to summer-practitioners, together with the opinion of the Legal Department of the American Medical Association, be turned over to the Secretary for a reply.

Yeas: 9. Nays: 0. Motion carried.

Re: Listing of Accredited Medical Schools

By Dr. Brook, seconded by Dr. Kelly:

That the list of accredited medical schools be continued, until the next meeting of the Board, (with the addition of Meharry Medical School since 1923).

Yeas: 9. Nays: 0. Motion carried.

Dr. F. C. Warnshuis appeared personally, and after an open discussion by the members, the following resolution was offered:

By Dr. Kelly, seconded by Dr. McIntyre:

RESOLVED, That Dr. F. C. Warnshuis be elected as Secretary of the Board of Registration in Medicine, for the ensuing two years, October, 1929, to October, 1931.

Yeas: 9. Nays: 0. Motion carried.

The President declared Dr. F. C. Warnshuis unanimously elected as Secretary.

By Dr. Nyland, seconded by Dr. Lemire:

RESOLVED, That the expenses of the Board members incurred during this meeting be approved.

Yeas: 9. Nays: 0. Motion carried.

Upon motion the meeting adjourned.

George L. LeFevre, M. D.,
President.
F. C. Warnshuis, M. D.,
Secretary.

Dated at Detroit, Michigan.
October 12th, 1929.

SECTION OFFICERS

The following section officers were elected at the Jackson Annual Meeting:

GENERAL MEDICINE

William Northrup	Chairman	1930	Grand Rapids
Milton R. Shaw	Secretary	1930	Lansing

SURGERY

Walter L. Finton	Chairman	1930	Jackson
G. C. Penberthy	Secretary	1930	Detroit

GYNECOLOGY AND OBSTETRICS

	Chairman		
Harry M. Nelson	Secretary	1930	

OPHTHALMOLOGY AND OTO-LARYNGOLOGY

J. M. Robb	Chairman	1930	Detroit
Carl F. Snapp	Secretary	1930	Grand Rapids

PEDIATRICS

M. Boyd Kay	Chairman	1930	Detroit
John Parsons	Secretary	1930	Ann Arbor

CALHOUN COUNTY

The September meeting of the Calhoun County Medical Society was held at the Battle Creek Country Club, Tuesday evening, September 3, 1929. The Kalamazoo Academy of Medicine was invited to join us in the third annual golf contest, twenty-one contestants participating in this part of the program.

At seven P. M. seventy-five fellows and ladies set down to dinner, which seemed to be enjoyed by all. Immediately following the dinner, after the adjournment to the ball-room, the meeting was called to order by Dr. Wilfrid Haughey, vice-president, who acted in the place of the president, who was absent. The minutes of the June meeting, as printed in the Bulletin, Vol. XII., No. 6, were adopted as printed. Under the head of new business, it was moved by Dr. Sleight and seconded by Dr. Gorsline, that in view of the fact that this Bulletin has been published the last year at a small profit, that the secretary be allowed any amount over and above the expense of publication of the Bulletin as an honorarium. Carried.

Dr. Gorsline moved that Dr. W. L. Godfrey, whose years of practice had passed the fifty year mark, be recommended to the State Society for honorary membership. Carried. It was also moved by Dr. Sleight that Drs. H. A. Shurtleff, of Marshall, and E. L. Palmeter, of Albion, be also recommended to the State Society for honorary membership for having been in practice for fifty years, and this was carried.

The following bills were read and paid:

Secretary's office expense	$8.50
Flagg's letter service	2.50

Under applications for membership, Dr. Stanley T. Lowe's name was read and referred to the board of censors.

The following names of members of other societies were read, and were voted into membership into this society.

Dr. Russell Mustard, from Washtenaw County.
Dr. A. L. Robinson, from Allegan County.
Dr. C. L. Ingalls, Homer, from Auburn, Indiana.

The chair next called upon Dr. Ward Collins, the president of the Academy of Medicine of Kalamazoo to take charge of the program, which was contributed by the visiting society.

After expressing his pleasure and delight in the cordial relations existing between these neighboring medical organizations, the first speaker, Dr. J. B. Jackson, was called upon and gave a short talk on the negative value of findings of the X-Ray, and stressed the fact that the X-Ray should always be viewed as the only one of the methods in use as a means of diagnosis. Routine X-Ray does not always disclose even fractures or bone lesions, and at times requires many films to be taken at unusuan angles in order to show us lesions. In kidney lesions, where stone is suspected, negative findings usually mean that no stone is present. Dr. L. E. Westcott read a paper covering some of the interesting points in diabetes melletis, and the control of insulin and diet in controlling this disease. This paper will doubtless be published in the State Medical Journal.

Dr. R. E. Balch gave a most interesting talk on some of the things which make up life and which, as serious minded doctors, we are all too prone to overlook. He expressed his love of the great out-of-doors, and of its moments of pleasure in making friendships while pursuing some hobby such as fishing, hiking, playing golf, etc. He waxed most eloquent in picturing the pleasant surprises that come to all unexpectedly "just around the bend." He was glad that we could not see too far into the future, as too often it would be depressing, and expressed the hope that the straight road would be short if we could see to the end. His talk, although it did not touch medical subjects, was most graciously received, indicating that the philosophical side of the doctor's life has a most interesting side when expressed so beautifully as was done by Dr. Balch.

Dr. D. C. Rockwell gave a very learned informal talk on the ear, and expressed the belief that the most serious ear troubles were preventable, but that 30 to 50 per cent of radical mastoid operations left behind complications of bothersome but more or less innocuous nature.

After expressing delight at having the Kalamazoo members present, the meeting adjourned.

Members present, 40.

Harry B. Knapp, Secretary.

BERRIEN COUNTY

The Berrien County Medical Society held their September meeting at the Four Flags Hotel in Niles on Wednesday evening the 11th.

A short business meeting was held at which the application of Dr. James U. Allen of Benton Harbor was voted on for membership and he was accepted into the society.

Announcement was made of the weekly broadcast of the Berrien County Society held each Monday at 12:00 noon over Station WEMC broadcasting on a wave length of 502 meters. This society is co-operating with the A. M. A. in disseminating information over the radio for a better understanding with the lay and medical fraternity, members of the society volunteering each week to read a paper. The Berrien County Society invite you to listen in.

The society was addressed by Dr. B. A. Shepard of Kalamazoo on tuberculosis and a general discussion followed his talk.

Announcement was made of the post-graduate conference to be held in Benton Harbor on the 16th of October tat the Hotel Vincent. The session will start in the afternoon at 1:30 and continue into the evening with time out for dinner at 6:30 p. m. An excellent program has been arranged with speakers from Ann Arbor and Chicago.

We wish to correct the omission of the name of Dr. Carter as the speaker at the August meeting when the society voted on adopting the County Health Unit. Dr. Carter was sent to us through the courtesy of the Michigan State Board of Health and answered the many questions of the members concerning the working plans of the health unit as well as giving a talk on the purpose of the health unit for counties.

W. C. Ellet, Secretary.

GRAND TRAVERSE-LEELANAU CO.

That the Post-Graduate Conference which was held at the J. D. Munson Hospital on October 11 was the best clinic ever held in the ninth district, was the opinion of the 48 physicians who came to Traverse City to attend it.

Members of the Grand Traverse-Leelanau County Medical Society succeeded in supplying a number of cases that applied to the various subjects under discussion, consequently making this conference very practical and more interesting to the audience.

Dr. G. F. Inch and the state hospital staff were hosts for a very excellent dinner which was thoroughly enjoyed.

E. F. Sladek, Secretary,

THE DOCTOR'S LIBRARY

Offering Suggestions and Recommendations

MEDICAL STATE BOARD QUESTIONS AND ANSWERS—R. Max Goepp, M. D., Professor of Clinical Medicine in the Graduate School of Medicine, University of Pennsylvania. Sixth edition, thoroughly revised. Octavo volume of 754 pages. Cloth, $6.00 net. W. B. Saunders Company, Philadelphia and London, 1929.

The present volume is based on a selection of questions asked during the last four years. The book will find its greatest use among those who are looking forward to state board examinations. The questions are arranged and classified according to subject and are answered as clearly and concisely as possible. The work might also be of value to those who care to review the different subjects of a medical course both academic and clinical which are presented in a catechism or question and answer fashion.

AN INTRODUCTION TO THE STUDY OF PHYSIC (now for the first time published)—William Heberden (1710-1801). A prefatory essay by Leroy Crummer, with a reprint of Heberden's "Some Account of a Disorder of the Breast." Portrait, 6 illustrations, 159 pages. Paul B. Hoeber, Inc., 1929, New York.

In rummaging through the shops of London second-hand book dealers, Dr. Crummer chanced upon a hitherto unknown manuscript by William Heberden, London physician of the eighteenth century. Being able to confirm the authenticity of the script, he presents the complete text in this little book. A prefatory historical essay deals with the relation of Heberden to modern medicine.

Heberden, known principally for his classic description of angina pectoris, wrote "An Introduction to the Study of Physic" as a guide for his sons. Essentially it represents a suggested curriculum of reading and study for a medical student of a century and a half ago.

The work should become a valuable source book for the student of medical history. The original description of angina pectoris is given as an appendix.

MATERIA MEDICA AND THERAPEUTICS INCLUDING PHARMACY AND PHARMACOLOGY—Reynold Webb Wilcox, M. A., M. D., LL.D Professor of Medicine (retired) at the New York Post-Graduate Medical School. Twelfth Edition. Revised in accordance with the United States Pharmocopeia X and the National Formulary V with an index of Symptoms and Diseases. P. Blackiston's Son and Company, Philadelphia, Pa.

The title describes briefly the nature and scope of this work. A commendable feature is the successful effort in reducing the size to less than 700 pages, which has been accomplished by clear and concise statement of the essentials of the subjects. The book is divided into two parts, the first dealing with materia medica and pharmacy; the second with pharmacology and therapeutics. The second part deals with the indications for drugs in a clear, brief and somewhat dogmatic way. The work has the authority of a long and ripe experience.

CLINICAL ASPECTS OF VENOUS PRESSURE—J. A. E. Eyster, B. Sc., M. D., Professor of Physiology, University of Wisconsin. Price $2.50. The Macmillan Company, New York.

This is one of the Macmillan medical monographs—a handy sized volume. It is the purpose of this volume to call attention to the importance of venous pressure. The author claims that venous pressure is the most direct indication that can be obtained clinically of the extent to which the heart is moving its volume of blood from the veins to the arterial side of the circulatory system. An extensive bibliography gives reference to the latest literature.

NEW ANESTHETIC REMOVES FEAR

A new anesthetic which puts patients to sleep so pleasantly and easily that they ask for more, has been reported by Dr. J. S. Lundy of the Mayo Clinic and Dr. R. M. Isenberger, professor of pharmacology of the University of Kansas. Fewer unpleasant after-effects and far less danger than many of the local anesthetics are claimed for this new aid to surgery, which has the impressive name of iso-amylethyl barbituric acid.

The work grew out of the old problem of how to offset the bad effects of some local anesthetics. Many investigators have sought means of avoiding the occasional cases of poisoning by cocaine. Accordingly, procaine, a synthetic product, was developed as a substitute for cocaine. However, bad reactions very occasionally follow even the use of procaine. Drs. Isenberger and Lundy, following along the line of some previous workers, found that certain substitution products of barbituric acid gave protection against convulsions from procaine. They reported their work with iso-amylethyl barbituric acid about a year ago.

In the course of a year's further work, Dr. Lundy has used iso-amylethyl barbituric acid, experimentally, and for the benefit of patients, over a thousand times. He has given it by mouth before administering local anesthesia and the apprehension from which some patients suffer before an operation has been lessened in this way. Moreover, convulsions, that occasionally come on from the use of procaine, have not appeared in any cases in which iso-amylethyl barbituric acid has been used.

Also, following the work of Zerfas, Lundy has used this product, by injection into a vein, to produce all or part of the general anesthesia in 273 major operations. Surgeons who have employed it in this way have found that patients wish to have it again if, for any reason, they need to have another operation. It quiets patients before operation and adds to their comfort after operation by producing a semi-conscious state for some hours after they have returned to bed. Nausea and vomiting are greatly lessened or entirely eliminated.

More work must be done on this subject before the product will, or should be used as commonly as morphine, ether and nitrous oxide now are used in general anesthesia. For some time, as with any new procedure in medicine, cases in which the substance is to be used must continue to be carefully selected to eliminate risk. However, with the interest that has been aroused by this work, by the use of carbon dioxide at the end of inhalation anesthesia as advocated by Dr. Yandell Henderson of Yale and by the report on the use of cyclo-propane that was given recently by Dr. G. H. W. Lucas of Philadelphia and Dr. V. E. Henderson of Toronto at the Thirteenth International Physiological Congress, patients who must undergo operations may, in the near future, be freed from the dread that some of them have of being put to sleep.—Science Service.

MEDICINE WINS ANOTHER TRENCH; RAYNAUD'S DISEASE OVERCOME

Medicine appears to have won another trench in its war against disease with the achievement of the surgical control of Raynaud's disease, recently reported by Dr. A. W. Adson and Dr. G. E. Brown of the Mayo Clinic. Raynaud's disease is painful, disabling and distressing to the patient, often ending in amputation of feet or hands. It has been compared to frostbite.

Everyone knows what frostbite is; that the supply of blood to a frostbitten area is interrupted; that if the injury is severe enough the frostbitten tissue is not nourished, dies and becomes gangrenous. Raynaud's disease is not frostbite. It is much more severe and it is not so definitely related to cold. However, the condition it produces looks and feels to the patient who has it something as frostbite looks and feels. Until recently, treatment for Raynaud's disease has been unsatisfactory. "The complete surgical control of Raynaud's disease would seem to be accomplished," Dr. Adson and Dr. Brown have now announced. They say "seem to be" and they use the word "control" rather than "cure". Genuine medical investigators do not claim too much too quickly. However, building on the foundations laid by other investigators, these two physicians in their attack on Raynaud's disease have directed their attention to the autonomic or sympathetic nervous system. This is the nervous system which works without any thought on our part. It helps to control our digestion, our heart beat and the tension of the walls of our blood vessels. These scientists found ways of removing small portions of this nervous system that lie in the back, behind the abdominal organs and in the upper part of the chest. When the right portions are removed, the tightness, or spasticity, of the affected blood vessels is relieved. This relief seems to be permanent, which gives rise to the hope that scientific medicine and surgery have conquered Raynaud's disease.—Science Service.

GERMLESS COMPOUND PRODUCES CHANGES LIKE TUBERCULOSIS

The characteristic tubercles or clumps of changed cells caused by the germ of tuberculosis can be produced by the injection of a chemical compound containing no germs at all, Dr. Florence R. Sabin of the Rockefeller Institute for Medical Research, New York City, reported to the National Academy of Sciences, Washington, D. C. Dr. Sabin's achievement is revolutionary. By it the most characteristic change produced in the body by a germ-borne disease has been obtained without the germ entering the body. This is the first time this has been done for any disease and introduces a new technique in the study of disease.

Dr. Sabin's discovery is one of the latest and startling results of the campaign for the investigation of the causes of tuberculosis in which about a hundred bacteriologists, chemists, physicians and pharmacists in all parts of the country are now engaged. This plan for co-operative research was organized by a committee of the National Tuberculosis Association, of which Dr. William C. White of the U. S. Hygienic Laboratory is chairman.

Hundreds of pounds of microbes are being grown in flasks containing the necessary nutrients and are turned over to the chemists of Yale University and other laboratories for analysis. The various fractions into which the material is separated are then tested on normal animals to discover the physiological effects of the different constituents. By this novel method of attack it is hoped to discover what the microbes are made of and what stuff it is that the creatures excrete which causes sound flesh and blood to degenerate into a cheesy mass of tubercles.

When the secret of the pestilential activity of

these parasites of the cell is found out, the doctors will be in a position to devise methods of counteracting it, for they will no longer have to work in the dark as they do today.

The compound used by Dr. Sabin is one of the fractions extracted from the tuberculosis bacilli by Prof. Treat B. Johnson and Dr. R. J. Anderson of Yale. It consists of an oil containing phosphorus, and is a compound hitherto unknown to chemistry, although similar in composition to the fats in our foods. After twelve doses of this compound, each dose containing as much of the substance as is contained in a gram of the dried "bugs", the tissue shows lesions closely resembling those of the disease. If the injections are not continued the lesions become gradually absorbed and almost disappear in a few months.

Other fractions from the chemical analysis of the cultivated bacilli consist of fats and waxes that have a similar effect in stimulating and disintegrating the cells of living tissues. This action of this substance is similar to that of the unknown cause of cancer, since this likewise excites the cells to abnormal multiplication and later results in their destruction. The tubercle bacillus invades the living cells and there lives and multiplies. This causes the cells to enlarge to an abnormal size and shape and these clumping together form the nodules known as "tubercles." This disastrous effect is perhaps due to some substance such as these that are now being isolated, excreted by the living microbe or coming from the decomposition of their dead bodies. —Science Service.

GREATEST PSYCHIATRISTS TO GIVE SALMON MEMORIAL LECTURES

A search for the scientist, famous or obscure, who has made the greatest original contribution of the year to the cause of preventing or treating mental disease is to be conducted annually. When the scientist is selected each year, either in this country or abroad, his work will be recognized by a new award, to be known as the Thomas William Salmon Memorial. He will be requested to give lectures in various cities of the United States.

This is the project designed to honor the memory of one of the outstanding American psychiatrists, Dr. Thomas W. Salmon, who died in 1927. Dr. Salmon was professor of psychiatry at Columbia University and had been the first medical director of the National Committee for Mental Hygiene. He took a leading part in establishing a psychiatric service for immigrants at Ellis Island, whch resulted in greatly lessening the number of mental charges admitted to this country. During the World War, he was a colonel in the American Expeditionary Force, acting as senior consultant in mental and nervous maladies of the fighting men. When he returned to the United States he endeavored to obtain for ex-service men model hospitals that would set a standard of excellence for the country. Dr. Salmon's friendly and sympathetic character as well as his notable accomplishments in the field of psychiatry so impressed his associates that 150 neurologists and pychiatrists launched the plan for a suitable memorial. Hon. George W. Wickersham is honorary chairman of the memorial. Honorary vice chairmen are Gen. John J. Pershing, Dr. Nicholas Murray Butler, Rev. Harry Emerson Fosdick, Mrs. Helen Hartley Jenkins, and Dr. John H. Finley. The initial $100,000 for the establishment of the memorial is being contributed by Dr. Salmon's friends, associates and laymen actively interested in the fields of nervous and mental diseases.

The lectures given in the United States each year are to be published and distributed, so that the knowledge on mental disease problems contained in them may be disseminated as widely as possible.—Science Service.

SMALLPOX NOT YET EPIDEMIC IN ENGLAND

Smallpox introduced into England by the passengers and crew of the liner Tuscania has not yet reached the proportions of an epidemic. This is the official opinion cabled by the U. S. Consul General at London to the Public Health Service, Washington, D. C. So far thirty-five cases have developed from contact with the passengers and crew of the liner, on which the disease was discovered before arrival from India at European ports. Smallpox is more or less prevalent throughout England. Vaccination is not compulsory, which increases the danger of a widespread epidemic. However, medical opinion in England is that the smallpox which is more or less continuously present is of a mild type and that compulsory vaccination is not necessary. The cases from the Tuscania may be of a more virulent type, however.

Quarantine officers of the U. S. Public Health Service are being especially vigilant in the search for cases of smallpox among travellers arriving at American ports from England, so that the disease will not be introduced into this country. English health officials are very efficient and will doubtless be able to check the spread of the disease without any epidemic resulting from the Tuscania cases. At the same time, public health officials advise Americans planning trips abroad this spring and summer to be vaccinated or revaccinated, if they have already had it done.

Vaccination should be done at least every seven years, in order to insure protection against this horrible and deadly disease. If the vaccination is properly done it will either "take" or produce an immune reaction. In the first case swelling, inflammation and possibly some pain will occur at the site of vaccination and the patient will thereafter be protected against the disease for a number of years. If a person is already immune, the vaccination will not "take" but there will be a slight reddening at the site of vaccination, showing that the person has in his blood the necessary antibodies to protect him against the disease.—Science Service.

FIND NEW ANIMALS THAT MAY TRANSMIT TULAREMIA

Tularemia, disease of rabbits, rodents and men, may also affect cats, muskrats, pigeons, ring-necked pheasants, grouse and quail, it appears from studies reported to the American Public Health Association by Dr. R. G. Green and E. M. Wade of the University of Minnesota and the State Department of Health. This new disease which has caused much concern in public health circles, is acquired by men who handle infected animals. The fact that many more kinds of animals may have the disease greatly increases the danger to human beings by increasing the possible sources of infection.—Science Service.